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The discursive maze of dual diagnosis

A Foucauldian discourse analysis of psychological practitioners' accounts of working therapeutically with clients

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The Discursive Maze of Dual Diagnosis: A Foucauldian Discourse Analysis of Psychological Practitioners' Accounts of Working Therapeutically with Clients

by

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Abstract

Dual Diagnosis (co-occurring mental health and substance use issues) is a pressing issue in health services. Despite its prevalence, research has demonstrated problematic practitioner-client relations; including stigmatisation and service-exclusion of clients, and confusion and fear among practitioners about working with this client group. There is also a referential ambiguity about the term dual diagnosis, and an absence of consensus among services about its definition. Dual diagnosis may therefore be considered a problematic discursive phenomenon, which is constructed in diverse and discontinuous ways. Practitioners' experiences of working with dual diagnosis clients is an under-researched area, to date. Moreover, there is a dearth of research on dual diagnosis in general within the discipline of counselling psychology. To address these shortcomings this research aimed to investigate practitioners' accounts of working therapeutically with dual diagnosis clients, to make visible these constructions and their power effects. Ten psychological practitioners (counsellors, psychologists and psychotherapists) were individually interviewed, and a Foucauldian Discourse Analysis was performed. The analysis identified several contradictory circulating contemporary dual diagnosis discourses, which circumscribed dual diagnosis practice. These discourses were deployed to resource five power-laden therapeutic subject positions. Four subject positions perpetuated asymmetric practitioner-client power relations, while one seemed to afford a more egalitarian practice. Overall, these findings are argued to contribute to the dual diagnosis literature by raising practitioners' awareness of the power relations in their talk about working with clients. They may therefore offer practitioners a resource to develop a critical reflexivity in their practice, which may mitigate its harmful power effects. This is argued to be of particular relevance to counselling psychology, given its commitment to reflexivity and engagement with issues of power.

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Transcription notation conventions

[…] indicates where material is deliberately omitted.
(text) brackets surround words for speech clarification.
(text) brackets with italicized words indicate where, for example, there is laugher.
[text] indicates a clarification of relevant information.
(.) indicates a short pause.

(Malson 1998; xv)

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Chapter One:

Problematising Dual Diagnosis in the Context of Psychological Practice

1.1 Introduction to Chapter One

Dual diagnosis refers to co-occurring substance use and mental health problems. It is recognised as a highly problematic phenomenon in contemporary mental health and broader health settings (e.g., Department of Health; DoH; 2002; McKeown, 2010). Issues include vexed practitioner-client relations that may involve stigmatisation and service exclusion, practitioners' uncertainty and negativity about effective practice with this client group, and an overarching confusion and lack of consensus about the definition of dual diagnosis itself. Problems for psychological practitioners—including counselling psychologists (CoPs)—thus arise from issues of language, in this area.

Although such problems with the language of dual diagnosis are evident, there is a dearth of research to date. In this study, I therefore used a qualitative approach to investigate psychological practitioners' accounts of working therapeutically with dual diagnosis clients. In doing so, I employed a poststructuralist epistemology to answer the research question: *"What are the discursive power relations in practitioners' accounts of working therapeutically with dual diagnosis clients?".* Ten psychological practitioners were interviewed about their experiences of therapeutic work with dual diagnosis clients. A Foucauldian Discourse Analysis (FDA) was applied to the transcripts of these accounts to illustrate their diverse discursive practices and contingent power relations.

In this chapter I will develop a rationale for undertaking this poststructuralist research. To do this I will first explore the problems of dual diagnosis, introduced above. I will then address its relevance to counselling psychology. Finally, I will outline the chosen poststructuralist epistemology and FDA method, and its relevance

for CoPs. This will provide a justification and context for the following chapters of this thesis.

1.2 The Problem of Dual Diagnosis

Dual diagnosis as a psychiatric term is rooted in the theoretical segregation of substance use and mental health disorders in diagnostic classification systems (McKeown, 2010). It was first used in the US in the 1980s to identify people within mental health or substance misuse services who also has a diagnosis that was treated by the other system, and initially appeared in inverted commas. Over time these were gradually dropped, and it is now an established client group (McKeown, Derricott, Stowell-Smith & Mercer, 1997).

Within the literature, dual diagnosis has increasingly emerged as a significant problem in mental health, general health and forensic settings. It is estimated to affect half of substance use service users, a third of mental health service users, and more than 70% of the prison population in Britain (e.g., DoH, 2002; McKeown, 2010; Mental Health Network, 2009, 2011; Prison Reform Trust, 2011). However, the epidemiological picture is unclear, and prevalence estimates vary widely (Hill, Penson & Charura, 2016; Schulte & Holland, 2008). Furthermore, while some have argued that its prevalence has been overestimated (Roberts & Jones, 2012), others have argued that these estimates significantly under-represent the scale of the problem (Rosenthal, 2015). This confusion may be unsurprising, given that there is currently no agreed operational definition of dual diagnosis (Hryb, Kirkhart & Talbert, 2007). "Classic" dual diagnosis refers to co-occurring severe mental health diagnoses and substance misuse (UK Drug Policy Commission, 2012). The National Institute for Health and Care Excellence (NICE; 2016) uses this definition, and specifies these diagnoses as "schizophrenia, schizotypal and delusional disorders, or bipolar affective disorder, or severe

depressive episodes with or without psychotic episodes" (p. 20). Substance use services, by contrast, tend to define dual diagnosis less strictly (Roberts & Jones, 2012). And clinicians have argued that a strict definition provides an arbitrary barrier to care that serves to exclude those who do not reach the required threshold (Guest & Holland, 2011; Velleman & Baker, 2008). Yet others have argued that looser definitions render the term meaningless (McKeown, Stowell-Smith Derricott & Mercer, 1998).

These disagreements about prevalence and definition are argued to illustrate the issues and ambiguities of language in contemporary dual diagnosis practice. At present, dual diagnosis may potentially be applied to a variety of combinations of mental health and substance use problems. It has consequently been criticised as an umbrella term that lacks clinical clarity (Cosci & Fava, 2011; Velleman & Baker, 2008). Indeed, clinicians have argued that dual diagnosis is not a diagnosis itself, but a descriptor of co-existing mental health and substance use disorders (Banerjee, Clancy & Crome, 2002). The term has also been criticised for its stigmatising capacity (Guest & Holland, 2011; Webb, 2010) and for representing the medical colonisation of the substance use care sector, with attendant issues of power and control (McKeown et al., 1998; Velleman & Baker, 2008). Dual diagnosis is therefore recognised both as a pressing problem—although how pressing seems unclear—and a confusing term that is critiqued and questioned yet widely used, including in the title of several peer-reviewed journals. Questions of language in clinical practice are to the fore, and worthy of research.

Further evidence of the ambiguities of language use are found in the literature regarding service provision. The *Dual Diagnosis Good Practice Guide* (DoH, 2002) stipulated that mental health services should be responsible for anyone with a severe mental health and substance use problem, with integrated care as the norm. Yet this guide provided no index for this severity, asserting

instead that local services needed to create their own, for the purposes of their inclusion criteria. From a linguistic perspective, this guidance may therefore have created more problems than it solved. Indeed, integrated care for dual diagnosis clients remains the exception to the rule (All Party Parliamentary Group on Complex Needs and Dual Diagnosis, 2014; Schulte, Meier, Stirling & Berry, 2008), and the separation of mental health and substance use services persists. There is now a recognised *ping-pong effect* (Lawrence-Jones, 2010) with dual diagnosis clients, who are often shuttled between mental health and substance use services, with negative consequences for their care. Moreover, this lack of integration may lead to clients being excluded from substance use services because of their mental health problems, and vice versa. Service exclusion is a significant problem for dual diagnosis clients (Home Office, 2017; NICE, 2016).

Interestingly, within these ambiguities and confusions, service users who receive a dual diagnosis are also described as problematic. For example, within the psychiatric literature dual diagnosis clients are variously described as "notoriously difficult to help" (Gerevich, Bacskai & Meggyes, 2005, p. 299), "an extremely challenging client group to engage" (Donald, Dower & Kavanagh, 2005, p. 1371), being quick to drop out of treatment (Horsfall, Cleary, Hunt & Walter, 2009), and making slow progress (Schulte, Meier, Sterling & Berry, 2010). There additionally seems to be much confusion about what may work therapeutically with this client group. While several psychological treatment protocols have been identified, including motivational interviewing, CBT and group counselling (Drake, O'Neal & Wallach, 2008; Horsfall et al., 2009), a recent Cochrane Review found "no compelling evidence" (Hunt, Siegfried, Morley, Sitharthan & Cleary, 2013, p. 2) for one protocol over another to engage clients in treatment, reduce their substance use or improve mental health.

The negative assumptions about dual diagnosis clients and uncertainty about effective therapeutic approaches seem to contribute to research findings that mental health professionals have experienced working with dual diagnosis clients as a seemingly impossible challenge (Coombes & Wratten, 2009), dual diagnosis workers can feel deskilled and helpless in dealing with their clients (Adams, 2008), and dual diagnosis training can erase practitioners' confidence (Roberts & Jones, 2012). Researchers have also found that mental health professionals can respond moralistically to clients' substance use, leading to questions about their deservingness of care (Chorlton, Smith & Jones, 2015). Prejudice and stigma by psychiatrists and other mental health professionals towards clients can be common (e.g., Avery et al., 2013; Ralley, Allott, Hare & Wittkowski, 2009). Research with dual diagnosis clients has echoed these findings. Clients have reported inadequacies in service provision and professionals' competencies and skills, while also experiencing stigmatisation (Lawrence-Jones, 2010). They have additionally reported misgivings about forming relationships with professionals, due to fears of being ridiculed or judged (Chorlton et al., 2015).

From these examples, the current picture of dual diagnosis clinical practice and service provision seems confusing and pessimistic. As the literature emphasises the enormity and intractability of the problem, it is also marked by disagreement about the term's definition, its prevalence, and the effectiveness of therapeutic approaches with the client group. Both practitioners and clients may approach interactions with trepidation and low expectations, and moralising judgements and service exclusion are ongoing problems.

Overall, it seems that problems of language predominate with dual diagnosis. In the context of the contemporary separation of substance use and mental health care provision, these have considerable implications. Disagreements over definition can lead to poor care, or no care at all (Velleman & Baker, 2008).

Moreover, the dual diagnosis label "*itself* can lead negative staff attitudes, poorer care and subsequently worse outcomes" (Ralley et al., 2009, p. 149). The literature thus demonstrates that the field's linguistic ambiguities and issues can have pronounced power effects, which may impact practitioner-client interactions. While dual diagnosis is an increasingly fertile research area, there is a paucity of studies of practitioners' experiences of therapeutic work with dual diagnosis clients. The problematic practitioner-client power relations identified in the above studies indicate that such research is warranted. Moreover, I argue, a poststructuralist study that attends to the power effects of practitioners' talk is appropriate, in this context.

My interest in dual diagnosis stems in part from my work in a substance use service, where I witnessed the effects of the separation of mental health and substance use support on dual diagnosis clients: I will return to this in Chapter 3. It is also rooted in my training as a counselling psychologist. In the next section I will discuss counselling psychology and the relevance of this research to the field in more detail.

1.3 Dual Diagnosis and Counselling Psychology

The discipline of counselling psychology is a comparatively recent development in the field of applied psychology. It emerged in the UK in the early 1980s as a response to increasing interest among graduates of psychology in its psychotherapeutic application. The British Psychological Society (BPS) set up a section of counselling psychology in 1982, and in 1994 it achieved full divisional status. Its origins were influenced by mainstream psychology, European psychotherapy and humanistic philosophy (Hanley & Amos, 2018; James, 2018; Strawbridge & Woolfe, 2010). This humanistic value base leads to a conceptualisation of humans as relational beings, and a similarly relational

perspective on psychological distress. It also marks out the discipline as distinct from other branches of applied psychology (Diamond, 2010; Hanley & Amos, 2018).

Reflecting its origins both within and outside psychology, counselling psychology is also rooted in a postmodern philosophical pluralism (James, 2018; McAteer, 2010; Rizq, 2010). It is therefore inclusive of multiple epistemological paradigms and therapeutic approaches. Indeed, counselling psychology training requires clinical competency in more than one therapeutic modality. This positions CoPs as flexible practitioners who can work with an array of problems in a range of settings (Strawbridge & Woolfe, 2010). CoPs therefore must negotiate diverse and sometimes contradictory theoretical models and ideologies in practice. This entails holding tensions, rather than resolving them (Orlans & Van Scoyoc, 2010).

One such tension is between CoPs' stance as both *scientist practitioners* and *reflective-practitioners*. The scientist-practitioner model is incorporated from clinical psychology and demonstrates counselling psychology's commitment to research and practice. The latter model demonstrates a commitment to self-reflection and an ongoing consideration of the impact of one's assumptions, feelings and actions on the therapeutic relationship (Hanley & Amos, 2018; Wolfe, 2016). These two perspectives may lead to competing visions of the nature of psychological research: scientific research is often within a positivist, quantitative paradigm predicated on statistical significance, which may be less relevant to counselling psychology's holistic view of the person. Consequently, counselling psychology adopts a methodological pluralism towards research. A range of methods are considered valid and useful (Hanley & Amos, 2018).

The tensions within counselling psychology are also prevalent in relation to medical knowledge systems of distress and psychiatric diagnosis. These are central to the scientist-practitioner model, and locate the practitioner as an active expert

applying knowledge to a more passive client, who is assumed to be suffering from identifiable symptoms (Woolfe, 2016). Yet from counselling psychology's humanistic perspective, the medical model may ignore context and the view of the whole person, and rely on normative assumptions. Larsson, Brooks and Loewenthal (2012) argue that counselling psychology is thus located between two competing epistemological positions regarding diagnosis. On the one hand, it should engage with the medical model while retaining a critical stance, and on the other it should uphold its nonpathologising and relational values (Woolfe, 2016). A commitment to egalitarian practice and an engagement with issues of power is thus required (Cooper, 2009; Steffen & Hanley, 2013).

Given its engagement with the medical model and interest in the therapeutic relationship, research on practitioners' experiences of working therapeutically with dual diagnosis clients is argued to be a relevant area of study within counselling psychology. There is also a paucity of counselling psychology research on dual diagnosis at present, which may be an omission given its apparent prevalence. Furthermore, counselling psychology attends to the use of language in practice, and its impact on client work. It recognises that "all theories about therapeutic practice situate clients and the conception of their problems in normative discourses" (Woolfe, 2016, p. 10). Therefore, a poststructuralist approach that investigates the power effects of practitioners' talk while maintaining a critical and non-essentialist stance towards knowledge is also suitable: although this may lead to further tensions with counselling psychology that I will discuss below. In the next sections I will describe this poststructuralist epistemology, with reference to the work of the French historian, critical theorist and philosopher, Michel Foucault (1926-1984).

1.4 Language and Poststructuralism

Poststructuralism refers to a heterogeneous group of ideas that arose in continental European philosophy during the political ferment of the 1960s and 1970s (Arribas-Ayllon & Walkerdine, 2008; Gergen & Gergen, 2008). These build upon structuralism's critique of the modernist notion of an objective and independent truth with discoverable essential principles, and a reality that is "both *prior to* and *independent of* representation" (Edley, 2001, p. 435). Structuralism posits that rather than reflecting reality, language constructs and organises it. Moreover, humans are the products, or *subjects*, of these necessarily social and relational processes. The "self" is therefore radically decentred. It is revealed not as an unchanging core essence, but as discontinuous and constantly in flux in the social situation (Burr, 2003; Gergen, 2015; Gergen & Gergen, 2008; Sarup, 1993).

Structuralism posits that while the relationship between signifier and signified is arbitrary, it is also stable, identifiable, and independent of individual use. It is therefore primarily concerned with investigating these structures. Poststructuralism, by contrast, holds that language is not a predictable system. Meaning is fluid, contestable and changing over time, and language has effects—not least in terms of power—beyond its structure and content. Consequently, poststructuralists focus on processes and representation in language as *discourse*. They investigate the causes and effects of discourses, and how they have been historically and culturally produced (Burr, 2003; Carter, 2013). From this perspective, social processes are inextricable from the production and nature of knowledge (Gergen, 2015; Hook, 2007; Randol, 2014). Poststructuralism is perhaps most strongly associated with Foucault (Carter, 2013; Sarup, 1993).

1.5 Foucault and Discourse

Although Foucault's earlier archaeological studies are structuralist, he came to focus on the power effects of discourse in the social construction of reality in his poststructuralist genealogical work (Carter, 2013; Weinberg, 2008). Here, his objective was to "create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 1983/2002, p. 326). Scholars have described Foucault's conceptualisation of discourse as referring to, or ways of constituting, bodies or systems of knowledge and encompassing the rules and divisions therein. Discourses invariably have a historical underpinning (e.g., Arney & Bergen, 1984; Arribas-Ayllon & Walkerdine, 2008; Carter, 2013; Miller, 2008). The delineation of *discourses-as-knowledge* (Hook, 2007) emphasises that these practices are inextricably linked to, and bound up in a circular and productive relationship *with,* the exercise of power. Discourses are self-legitimating versions of the world that societies "accept and make function as true" (Foucault, 1980/1991, p. 73). As *regimes of truth*, they disqualify competing versions (Miller, 2008) such that they may be considered "weapons of attack and defence in relations of power and knowledge" (Sarup, 1993, p. 66). In determining "what can and must be thought" (Foucault, 1984/1992, p. 6), discourses constitute humans as subjects. Thus, discourses are simultaneously productive and constraining. They are opaque, strategic and power-laden (O'Callaghan, in press): this conceptualisation of discourse is argued to be suited to research investigating dual diagnosis practitioners' talk, given the linguistic confusion and asymmetric power relations that may characterise dual diagnosis practice.

Foucault was particularly concerned with the role of the sciences in the production and propagation of discourse. He argued that in the late 18th century, the incipient medical sciences deployed new discourses that functioned as *dividing practices* (Foucault, 1983/2002). These discourses facilitated the establishment of

norms that served to categorise, individualise, and produce new types of humans with highly efficient and subtle power effects (e.g., Foucault, 1975/1991, 1976/1998, 2001). Of relevance to this study, Foucault (1964/2001) contended that an emerging eighteenth century discourse of madness-as-disease served as a dividing practice to constitute and separate the sane from the insane: these figures came into being as this discourse's product and effect. This discourse both made modern psychiatry possible and imbued it with a legitimacy and authority that facilitated its development as an expert position (Joranger, 2016; Loewenthal & Snell, 2003; Zhao, 2012): I will return to this in Chapter Two.

Foucault (1983/2002) additionally argued that through discourses humans constitute themselves as subjects. In this *submission of subjectivity*, these discourses function as a "law of truth" (p. 331) that humans recognise in themselves and others. Thus, they unwittingly recruit themselves into these relations of power/knowledge (Bailey, 2005; Rose, 1998). The problematisation of dual diagnosis clients in the literature discussed above, alongside practitioners' reported difficulties with these clients, suggests that such processes may be at work in contemporary dual diagnosis practice. The analysis below intends to address this.

Scholars have divided Foucault's oeuvre into sections, which broadly relate to his differing conceptualisations of power (e.g., Miller, 2008; Thompson, 2003). In his earlier and middle work, power is conceptualised as a strategic force permeating all levels of society. In this top-down model the subject is entirely constructed, or subjected, by discourse, and ensnared within its power relations (Miller, 2008; Vintges, 2012). Foucault's conception of *disciplinary power* (1975/1991), which produces docile bodies and behaviour through individualising practices of hierarchical observation, normalising judgement and examination, is emblematic of this strategic model.

However, Foucault (1976/1998) also argued that resistance is a necessary precondition for the existence and exercise of power, and vice versa. Within the strategic model's totalising power relations, it is unclear to what extent resistance is possible (Miller, 2008). Moreover, this resistance is conceptualised as a direct confrontation of a dominant power that is bound to be futile because it is "always determined by its engagement with an ascending force; its only options are to comply with or refuse the challenge" (Thompson, 2003, p. 120). This model failed to account historically or conceptually for the workings of power, resistance and subjectivity.

Therefore, in his late work Foucault reconceptualised power as *governmental*. In this model, it indirectly acts on actions by determining their "field of possibilities" (Foucault, 1983/2002, p. 341). Here, freedom is intrinsic to the operation of power (Thompson, 2003). This freedom may take the form of a *technology of the self*, in which people perform various operations on their own thoughts and conduct (Foucault, 2000d). However, this may also render them subject to their own identities such that they may "act out of a tendency to conform to the regulations and ongoing practices of the various social agencies that define and shape these identities" (Thompson, 2003, p. 130). The truth-telling practices of psychotherapy are particularly implicated here, within which the confessional self is formed (Besley, 2005; Burr & Butt, 2000; Rose, 1998). The governmental model thus provides a more robust account of how humans construct themselves through the available discursive resources, and how they become self-regulating subjects.

In his final works, Foucault (1984/1990, 1984/1992) returned to these technologies of the self as potentially offering a degree of emancipation from these power relations. Key here is the practice of critique, through which "we pose the limits of our most sure ways of knowing" (Butler, 2001, p. 3). Critique thus

involves refusing the individuality that has been imposed, particularly through scientific discourses. Bringing it to bear on technologies of the self facilitates an relatively autonomous and ethical self-formation leading to more egalitarian relationships with others, rather than a self-regulation that perpetuates these relations of power (Thompson, 2003; Vintges, 2012). This research will consider the strategic and governmental models of power, and the relatively emancipatory potential of critique, to highlight the power relations in participants' accounts of working therapeutically with dual diagnosis clients.

1.6 Foucault, the Poststructuralist Epistemology and Counselling Psychology

In asserting the primacy of discourse in constructing reality, a poststructuralist epistemology takes an anti-essentialist and relativist position that unsettles the aforesaid modernist notions of truth, reality, and objectivity. Foucault, who once trained as a psychologist, argued that psychology played a prominent truth- and reality-producing role in contemporary society, and thus had a central place in modern governmental economies of power (Hook, 2007).

This epistemology was introduced into psychology in the 1980s, in the form of FDA (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013). In keeping with Foucault's conceptualisation of his work as an 'antiscience' through which traditional narratives of subjectivity and truth are reread (Carter, 2013; Hook, 2007), its introduction was intended to challenge the assumptions of mainstream psychology, as well as highlighting how it constructs the objects that it studies and purports to explain. Consequently, FDA is strongly linked with critical psychology (Willig, 2013; Parker, 2013).

This research method may be considered part of a *critical-ideological research paradigm* (Ponteretto, 2005) that views lived experience as constructed in language and "mediated by power relations within social and historical contexts" (p.

130). Research thus aims to reveal the constructed nature of experience and our taken-for-granted assumptions, and the strategic and ideological power relations therein, so that we might liberated from their grasp (Gergen & Gergen, 2008; Ponteretto, 2005; Parker, 2013; Hook, 2007). As I will discuss in Chapter Three, the present research is located within this critical-ideological paradigm.

While this seems in keeping with counselling psychology's commitment to engage with power issues in practice, this research method may also be in tension with counselling psychology itself, as a professionalized discipline of applied psychology. I think that this tension is further enhanced by counselling psychology's humanistic roots. Foucault was profoundly critical of humanism which, he argued, underpinned the Enlightenment and its human sciences that constituted the modern subject and entrapped this subject within totalising relations of power (Alessandrini, 2009; Olssen, 2003). I will consider this tension in Chapter Five.

1.7 Overview of Aims and Potential Contribution of this Research

This chapter has argued that dual diagnosis is a problematic clinical phenomenon. Terminological confusion and debate are at the fore with this phenomenon. Research has also demonstrated that asymmetric power relations can be prevalent between dual diagnosis practitioners and clients. It may be unsurprising, therefore, that dual diagnosis has been described as a "vexed discourse" (Roberts & Jones, 2012, p. 666).

However, there is currently a paucity of research on the experience of therapeutic practice with this client group, not least within counselling psychology. This research intends to address this shortcoming by investigating ten psychological practitioners' accounts of working therapeutically with dual diagnosis clients. In doing so, a FDA is applied to attend to the discursive power games within these accounts. This method is argued to be appropriate, given the aforesaid problematic

discourse and practitioner-client power relations. The application of a critical poststructuralist epistemology to this research aims to alert practitioners—not least counselling psychologists—to the discursive resources they may draw on in their practice with this client group, and the discursive rules that may shape their understandings. It also aims to raise practitioners' awareness of the power relations they may unknowingly be situated within, and the regimes of truth they may both be subject to and perpetuate.

To address these aims, in Chapter Two I apply this poststructuralist perspective by offering a genealogical analysis of dual diagnosis. In Chapter Three I detail the methodology and method adopted in this research. Chapter Four presents the findings of this research's FDA of ten practitioners accounts of working therapeutically with dual diagnosis clients. In Chapter Five I offer a conclusion for this research by discussing and evaluating its findings and possible contributions to the field of psychological practice with dual diagnosis clients, and counselling psychology more specifically.

Chapter Two

A Genealogical Approach to Dual Diagnosis

> "However, if the genealogist refuses to extend his faith in metaphysics, if he listens to history, he finds that there is 'something altogether different' behind things: not a timeless and essential secret, but the secret that they have no essence or that their essence was fabricated in piecemeal fashion from alien forms" (Foucault, 1971/1991, p. 78)

2.1 Introduction to Chapter Two

In this chapter I will review relevant literatures by providing a genealogical study of dual diagnosis. As a critical history, Foucault used a genealogical lens to trace the emergence and historical course of discourses in their wider social, political and cultural context, to provide a history of their present uses. In exposing the contingency, complexity and fragility of these historical foundations, genealogy defamiliarises the present and unmasks the institutional and embodied power effects of discourses, so that they can be contested (Hook, 2007).

Dual diagnosis is a contemporary psychiatric term, informed in its present uses by diverse historically inherited discursive resources. I will detail its discursive production in the context of Foucault's (1964/2001, 2000c) critical histories of psychiatry and mental illness and more recent examples thereof (e.g., Porter, 2013; Scull, 2015), and genealogical studies of addiction (e.g., Fox, 2015; Levine, 1978, 2015; Reinarman 2005; Reith, 2004; Room, 2015; Valverde, 1997). I will note the discursive turns in constitutions of mental illness and addiction, the convergences and divergences of these discourses and their subjects—the mental patient and the addict—and how they are combined in dual diagnosis with specific power effects. In keeping with this study's poststructuralist epistemology, in this chapter I assume that these discursive phenomena do not pre-exist language but are constituted through circularly productive social processes. From this perspective, medical and psychological discourses produce the phenomena they claim to describe and explain.

2.2 Foucault, the Genealogy of Madness, Psychiatry, and the Psy-Complex

In *Madness and Civilization* (1964/2001), Foucault traced the birth of psychiatry and its modern constructions of madness as mental illness. He argued that these emerged in the context of the Great Confinements of the poor, sick and unemployed in seventeenth century Europe. These were both a political decision designed to prevent civil unrest, and a moral one, rooted in an emerging bourgeois ethic of the virtue of work. Confinement thus represented a synthesis of morality and law. Prior to these confinements madness was broadly considered a natural, if extreme state: Porter (2013) claims that religious constructions of madness as divine or demonic possession predominated. The mad were beyond reason, but not sick, and were initially undifferentiated from the other internees in the confinement houses. However, within these houses the mad came to be distinguished through this new bourgeois ethic, by their apparent willingness to exclude themselves from work. Thus madness began to be constituted in moral terms, and "the solidarity between sick and healthy, unreason and reason, disappeared" (Joranger, 2016, p. 314).

Throughout the eighteenth century a new medicalised construction of madness emerged, within this bourgeois moral frame of intelligibility. It was theorised to result from nervous irritation due to overstimulation, which excessive passions of all types could trigger. This incorporated guilt into the concept: one's own feelings were the cause of insanity. Thus, madness was constituted as "*the psychological effect of a moral fault*" (Foucault, 1964/2001, p. 148). This made a distinction between physical and mental treatment possible, providing a space for psychiatry to emerge. Porter (2013) asserts that these secular discourses were partly deployed by the ruling classes because they held greater potential for social control than religious discourses, which had proved ineffective in this regard.

During the eighteenth century, a *great fear* of confinement houses as the source of a contagious madness gradually spread throughout society, which was

rapidly changing. Liberty, knowledge and civilisation itself were considered potential causes of madness, by arousing the passions excessively. This discourse was formalised in several new disease constructs. In England, George Cheyne (1671-1743) conceptualised *the English malady*, a nervous disease caused by—and a mark of—civilisation. In America, Dr Benjamin Rush (see below) similarly conceptualised *anarchia*, an insanity resulting from excessive passion for liberty (Scull, 2015). These newly constituted mental disorders seemed to serve as a repository for broader concerns about modernity and social change.

A vigorous critique of confinement then arose, centred on the mad. However, the injustice was that others were confined with them: confinement itself was now considered another source of madness. The rationale for general confinement collapsed. Yet the insane were considered too socially disruptive and economically unproductive to release, and so were imprisoned.

According to the legend of psychiatry's birth, the enlightened pioneers Philippe Pinel (1745-1826) in France and William Tuke (1732-1822) in England entered the prisons and delivered the mad from their brutal internment, establishing in the process the new science of psychiatry and its humane asylums. However, Foucault (1964/2001) argued that this myth obscures a more complex arrangement. Tuke and Pinel instigated treatment regimes that were predicated on constructions of madness as a breakdown of morality and rationality, and organised around the principles of judgement and surveillance. Through the latter, the former was perpetual, and punishment immediate. The mad were to recognise their own madness, take responsibility for their actions that led to it, and feel remorse. They were to enact their own self-restraint, through which they would be liberated from their illness. This introduced notions of the will and willpower into madness, which were—and remain—central to medical constructions of addiction; see below. Through

surveillance madness increasingly came to understood and recognised through norms of behaviour. This made psychology as a distinct discipline possible.

The asylum thus embodied the bourgeois moral code. The mad were expected to learn work's virtues. Self-control and familial devotion were emphasised. In this moral order, the doctor assumed the form of the parent and judge, confronting the childlike madness and weak will of the insane. Indeed, the physician's superior character, expertise and moral example established a psychological and moral ascendancy over his charges that was considered optimally efficacious (Porter, 2013). Those who transgressed this moral code by failing to show remorse, refusing to work or stealing, were systematically excluded from this family. This seems to prefigure the current widespread exclusion of dual diagnosis clients from mental health services, justified by their failure to maintain abstinence (see section 1.2).

Therefore, Foucault (2000a) argued, the asylum enacted dominating power relations whereby the insane became "citizens without rights, delivered over to the arbitrariness of the doctors and orderlies, whose own power increased symmetrically with the diminishment of their charges" (p. 48). The pioneers of psychiatry freed the mad from their iron manacles, only to enchain them more comprehensively in this regime of moral and psychological constraint.

Psychiatrists' authority derived from this double role of parent and judge. In the ensuing decades, this was obscured as psychiatry increasingly deployed discourses of positivism, such that today this authority is thought to stem from their medical status. Yet for Foucault (1964/2001, 2000c) psychiatry remains an indelibly moral practice. This assertion seems to be supported by the above descriptions of dual diagnosis clients as "lacking motivation" and being "notoriously difficult to help", within the literature (see section 1.2). Foucault (2000c) later noted that the positivistic discourse of psychiatry was—and remains— inevitably circular. Psychiatry constructed a morality-based and behaviourally normative "truth" of madness as a

disease. It then developed the tests to confirm and manifest this truth, based on these norms. And through this new knowledge psychiatry justified its medical power, and madness was confirmed as such a disease. In short, psychiatry produced the symptoms it described, and on this basis administered its treatments. This had dramatic power effects. Madness was:

> constituted as an object of possible knowledge for a medical science, that constituted it as an illness, at the very moment when the "subject", stricken with the illness, found himself disqualified as insane—which is to say, stripped of any power and any knowledge concerning his illness (Foucault, 2000a, p. 49)

Psychiatry thus became a dividing practice *par excellence*. It produced and individualised the mentally ill, and delineated them from the rest of society. Indeed, the asylum was a "marvelous harmony" (Foucault, 2000c, p. 49) between a state wanting social control, and a medical profession wanting the isolation of patients to establish and enhance its status: in England a medical presence was required by law in all asylums after the 1820s, and a letter from a physician was required for confinement (Porter, 2013). Moreover the state took an increasing role in confining the mad, through licensing asylums and standardising care. This coincided with the century's exponential growth in the asylum population, which Scull (2015) argues was the true Great Confinement. These numbers were predominantly drawn from the industrial working classes, and women were disproportionately the recipients of mental treatments both within and beyond asylums (Porter, 2013).

Although Foucault did not articulate his strategic power model until some two decades after *Madness and Civilization* was published, the power relations therein exemplify it. Normalising judgement and surveillance were key instruments by which he theorised that disciplinary power functions (Foucault, 1975/1991). Perhaps these power relations also prefigure those of governmentality, since treatment involved patients regulating their own behaviour to rejoin society.

Others have expanded upon Foucault's argument and its governmental implications in articulating the *psy-complex* (e.g., Danziger, 1990; Parker, 2018; Rose, 1985, 1998); the disciplines of psychiatry, psychology, psychotherapy and psychoanalysis that, through their inexorably expanding bodies of knowledge, have been responsible for the "production and complexification" (Guilfoyle, 2001, p. 151) of the individual in the West. The psy-complex's diverse systems of knowledge enjoin people "to govern themselves as subjects simultaneously of liberty and of responsibility" (Rose, 1998, p. 12). It continues to spread throughout life, problematising new domains.

2.3 A Genealogical Approach to Addiction

In this section I will summarise scholars' contributions to a genealogy of addiction, to highlight the discursive turns that have influenced its present medical problematisation of behaviour. In doing so I will focus initially on alcohol consumption, in relation to which addiction was first articulated before being applied to consumption of other substances. I will detail the various constructions of addiction of the past two centuries, their subjects, and their power relations.

2.3.1 Drinking in the pre-Modern and early Modern era.

References to alcohol consumption and drunkenness date back to the earliest recorded human history. Winemaking reached ancient Greece around 2000 BCE, and the Romans subsequently spread it throughout their empire: the term addiction is Roman in origin, signifying a legal designation of enslavement as punishment for unpaid debts (Smith, 2010). The ancient bacchanalian drinking traditions held sway in the West until the Middle Ages. Drinking was part of everyday life for millennia, and drunkenness considered its common and harmless consequence. The medieval

figure of the drunkard was presumed to drink because he or she enjoyed it. No internal flaw was inferred (Levine, 2015; Nathan, Conrad & Skinstad, 2016).

In the early modern era, concurrent with the Great Confinement, protestantism and capitalism combined to create capitalist market economies, which rapidly transformed society. Traditional support networks weakened, and families became highly reliant on people's capacity to regulate their own behaviour to succeed. This led to the constitution of the modern Western liberal self as free-born and possessing a free will. This discourse objectified the liberal subject as rational, autonomous, self-directed and sober (Levine, 2015; Reinarman & Granfield, 2015, Room 2015; Rose 1998; Weinberg, 2008). It underpinned the aforesaid bourgeois moral code.

At the same time, there was a massive upsurge in consumption of grain-based spirits. Low taxation and large harvests meant they rapidly replaced wine and beer due to their cheapness. This caused a sharp rise in drunkenness, and serious health consequences including a spike in infant mortality. It reached its peak in the British *Gin Crazes* of the 1730s and 1740s, which led to history's first drug scare (Brennan, 2004). New constructions of alcohol and drunkenness as a threat to society emerged, and Parliament raised taxes and passed new laws to limit its consumption (Duff Gordon, 2017; McCandless, 1984). This moral panic, like the great fear of confinement, may have functioned as a repository for concerns about societal change.

Throughout the eighteenth century religious discourse began to problematise drunkenness for its deleterious effects on piety and productivity. Protestant clergymen sermonised on its ills. They noted drunkards' apparent difficulty in giving up their habit and their suffering in this world and the next, which their routine avoidance of social and familial responsibilities would ensure (Levine, 1978, 2015). Discursively, drink and the drunkard had assumed more pernicious forms.

2.3.2 The discursive production of addiction as a disease.

These historical circumstances provided the context for the emergence of the modern medical construction of addiction, in the late eighteenth century. According to Levine (1978, 2015), the key figure in this process was the American physician, social reformer and politician—and proponent of *anarchia*—Dr Benjamin Rush (1746-1813). He proposed that drunkards were addicted to alcohol, and this addiction took hold progressively. He conceptualised this addiction behaviourally, as a loss of control over drinking. This, he argued, was a disease of the will, named alcoholism. And he proposed a cure of total abstinence. In Britain, the Naval doctor Thomas Trotter (1760-1832) independently and concurrently came to a similar conclusion (Edwards, 2012; McCandless, 1984). Rush (1812) and Trotter (1804) thus reconstituted the harmless drunkard as the diseased alcoholic. They also constructed this new disease of alcoholism, which was recognisable through behavioural norms. They claimed this figure and disease for medicine and laid the foundation for its psychiatric and psychological treatment. As the will was the disease site, alcoholism was a necessarily modern and liberal affliction (Valverde, 1997). It seemed to share a moral root with medical constructions of madness (see section 2.2). The resilience of this construction is evident by its continuing centrality to the ideology of Alcoholics Anonymous; see below.

Rush (1835) additionally proposed that these alcoholics should be treated in *Sober Houses*, where they might be confined against their will. He justified this on the grounds of maintaining order, as their compulsiveness was a threat to society (Duff Gordon, 2017). This objectified alcoholics not merely as diseased, but dangerous: the interests of medicine and the state seemed to align here, too.

Moreover, I argue, the alcoholic was rendered childlike through this incapacity to exercise self-restraint, and inferior to the patriarchal doctor whose willpower remained exemplary. As unruly children, their enforced treatment was

justified. The alcoholic seemed to have been located within similarly asymmetric power relations as the mental patient, and the product of the same social and political forces.

Scholars have argued that the concept of alcoholism predates Rush and Trotter by decades (e.g., Berridge, Walke & Mold, 2014; Porter, 1985). However, it was in their work that the disease concept, its product the alcoholic, and the medical profession's central role in its diagnosis and treatment was first fully articulated. This marked a significant discursive shift, which engendered new power relations around alcohol. These ideas were initially slow to spread in the nineteenth century. Heavy drinking remained commonplace, and alcohol's effects were not considered inevitably deleterious throughout society (Levine, 1978, 2015; Porter, 1985). The popularisation of this discourse was primarily due to two interrelated processes against the backdrop of the era's immense changes: the evangelical temperance movement and the drive to professionalise medicine.

2.3.3 Addiction in the nineteenth century: the temperance movement.

The temperance movement, which grew to become the largest mass-movement of the century in the US and a similarly potent force in Britain, took Dr Rush as its founder. His constructions of the alcoholic and social consequences of alcohol, and recommendation of a curative total abstinence, formed its ideological core. However, the movement also constituted alcohol as the inherently addictive *demon drink*, which accounted for the alcoholic's incapacity to resist it (Levine, 2015; Reinarman & Granfield, 2015; Room, 2015). This discourse objectified the alcoholic as out of control, but now due to forces outside of him or herself. It therefore seemed to repeat earlier Christian constructions of madness as demonic possession. Moreover, the movement promulgated the notion that alcoholism caused

insanity. Madness and addiction were linked again, as consequences of similar causal processes.

Room (2015) argues that the temperance movement was also propelled by, and served as a vehicle for, society's burgeoning concern with self-control in the rapidly industrialising western world: this was accompanied by dramatically increasing levels of consumption that were feared to be a threat to social and moral order (Reith, 2004). These conditions proved ripe for the construction of alcohol as an addictive substance that made people behave in ways they otherwise would not. Demon drink discourses thus took on a powerful explanatory function regarding people's loss of this prized self-control. They also explained why some people continued to drink in the face of the temperance movement's concerted attempts to build a sober society (Room, 2015). These ideas persist in contemporary medical constructions of addiction. A key criterion for positive diagnosis is continued use despite knowledge of harmful consequences; see below.

Temperance discourse, then, problematised alcohol as a mortal threat, both to the individual and society. In so doing, it promoted notions of the ideal, self-controlled liberal self. In Britain, the temperance movement shifted official Church of England policy toward abstinence by the end of the century, with varying power effects. The Church advocated complete abstinence for the proletariat, but moderate consumption for the upper and middle classes (Olsen, 1994). These class distinctions were also inbuilt in medical constructions of addiction during this period.

2.3.4 Addiction in the nineteenth century: The medical profession.

The disease construction of alcoholism also appealed to the nascent medical profession. Before the medical registration measures of 1858, there were no strict parameters for qualified medical professionals in Britain. Professional status, however, was essential for the establishment of its authority as a modern scientific

discipline. This required new knowledge systems and medical techniques to designate and categorise disease, and so legitimise this status. By valorising alcoholism discourses, the alcoholic could be brought under its control (Berridge, 1997; Foxcroft, 2007).

There was a strong relationship between the temperance movement and the medical profession. However, the question of alcohol's harmfulness was as divisive in the medical community as in society. While many doctors advocated abstinence and signed public declarations about alcohol's perils, others advocated its use in treatment (McCandless, 1984; Olsen, 1994). The medical profession was similarly divided about opium, with some doctors arguing it caused insanity while others extolled its medicinal virtues (Foxcroft, 2007). And while temperance and medical perspectives on alcohol sometimes overlapped, the former conceptualised the problem lying more with the substance while the latter problematised the individual (Smith, 2010; Weinberg, 2013).

The view that addiction caused insanity was popular in the medical community, particularly among those affiliated with the temperance perspective (Porter, 1985). The medical profession developed numerous disease constructs to link addiction and insanity, which Valverde (1997) argues were designed to bring those who did not fit diagnoses of insanity under its gaze. *Degeneracy* was based on Lamarckian theories of heredity. Parental drunkenness was theorised to be passed down to the children along with its accompanying criminality, idiocy and insanity. The drunkenness of one generation would lead to a progressive degeneration in the next, and the eventual extinction of the family line through infertility within four generations (McCandless, 1984). This discourse also underpinned later nineteenth century medico-legal discourses of *abnormality*. Abnormals included both addicts and the mad (Foucault, 2000a, 2016).

Degeneracy discourse was a potent dividing practice. The psychiatric profession, which by the latter third of the century was in crisis, seized upon it. Its moral treatments had proved far less successful in curing madness than it had initially claimed. But by objectifying patients as pathologically deficient in willpower and having a "morbid constitutional defect" (Scull, 2015, p. 303), psychiatry could present itself as performing a crucial function by protecting society from these degenerates' malignancy (Scull, 2015). This discourse's power effects were formidable. They would eventually lead to eugenicist sterilisation policies in the US and UK (Smith, 2010).

Later in the century the disease construct *inebriety* emerged, which incorporated alcohol and opiates. Its chief proponent was the temperance movement campaigner and physician Dr Norman Kerr (1834-1899), who founded the Society for the Study of Inebriety (known today as the Society for the Study of Addiction and publisher of the journals *Addiction* and *Addiction Biology*). This society advanced the disease concept of addiction, and promoted medical treatment rather than incarceration. It advocated a partnership between the state and the medical profession to meet these ends (Berridge, Walke & Mold, 2014). Inebriety became a legal definition, referring to the loss of will to make moral decisions due to intoxication (Berridge, 1997). A network of public inebriate asylums was set up around the UK, and compulsory commitment instituted (Valverde, 1997).

Kerr proposed that inebriety led to functional brain changes, but these changes could only happen because of an underlying lack of willpower that was passed down from earlier generations (Berridge et al., 2014). Inebriety thus seemed to share degeneracy's deterministic hereditarian basis (Berridge, 1988). Despite its scientific assertions, the will continued to be the disease site and the focus of treatment. Valverde (1997) has noted a paradox here: inebriates were characterised by a

diseased will, but their recovery wholly relied on them engaging this diseased part of themselves.

Like degeneracy, inebriety discourse produced a figure who lacked willpower profoundly. This inebriate was also ensnared in dominating power relations, in which the interests of medicine and the state intertwined. Those committed to state-run inebriety asylums could be held for three years. This group consisted predominantly of mothers accused of neglecting their children, and prostitutes. Gentlemen, meanwhile, were believed to have sufficient willpower but an excess of desire, and were voluntarily confined to private retreats where treatment focused on moral matters (Valverde, 1997). These disorders also functioned as containers for fears about social change: greater susceptibility among the industrial working classes was assumed (McCandless, 1984; Weinberg, 2013).

2.3.5 Conclusion to addiction in the nineteenth century.

By the end of the nineteenth century, alcohol and its consumption had been dramatically reframed, discursively. Temperance and medical addiction discourses had proliferated. The subjects that these discourses produced—the alcoholic, the degenerate, the inebriate—were the antithesis of the liberal subject. They seemed to take on a powerful pedagogical function as constant reminders of the need to maintain self-control, and the perils that befell such failure. Thus, they were potent governmental tools. As Reith (2004) writes,

> The addict was a 'made up' person whose parents were a convergence of interests between the industrial state and the medical profession, and who linked the individual with the social body. Addicts served as repositories for widespread fears of unrest - a group who had a deviant identity stamped upon them, so they could be just as forcibly 'cured' (p. 290).

The moral underpinning of these constructions and their cures linked them to psychiatric discourses of mental illness. However, it also accounted for their discursive instability. Ultimately, they could not explain how to rebuild their

proposed disease site, the will, except in moral terms. This contravened the medical profession's self-assertions of its scientific status (Valverde, 1997).

2.3.6 Addiction in the twentieth century.

Perhaps due to their instability, medical addiction discourses lost favour in the early twentieth century. The state reclassified inebriety as a "constitutive peculiarity, or even more modestly, a habit" (Valverde, 1997, p. 268), repealed its compulsory treatment legislation, and defunded the inebriety asylums (Valverde, 1997). The temperance movement also shifted its focus toward encouraging prohibitionist legislation (Levine, 2015). Alcohol and the alcoholic were constituted exclusively as social problems, and fell under the state's control.

New discourses of *addiction*, referring only to drugs, emerged and superseded inebriety in medical knowledge systems. These prioritised craving symptoms (Berridge et al., 2014). They may partly have been expedient, in affording medicine continued control over substances that the state had not yet reclaimed: the government classified this new disorder as a disease needing treatment in 1926 (Berridge, 1997). While Berridge and colleagues (2014) have argued that this addiction construct had less moral baggage than inebriety, its emphasis on craving seemed to problematise the addict's desire. Indeed, addiction was still objectified as a vice that eventually became a genuine disease with an identifiable pathology (Berridge et al., 2014). The addict's moral fibre was still the source of his or her predicament.

The post-World War I peace settlement also saw the establishment of an international drug control system, and the onset of national drug-regulation policies. This prohibitionism was partly motivated by concerns about social breakdown, once more. Young women and the working classes were considered especially susceptible

to drugs, and their accompanying moral degradation (Mountian, 2013): this seemed to mobilise possession discourses.

2.3.6.1 *Alcoholics' Anonymous and psychoanalytic models of addiction.*

Addiction discourses shifted again in the 1930s, following the end of prohibition. Alcoholism was reconstituted as a medical condition through the discourse of the Alcoholics Anonymous (AA) movement. AA deployed medical discourse by constructing addiction as a progressive and irreversible disease, although this was spiritual and rooted in drinkers' selfishness: this model continued to problematise the will. Alcohol was cast as a socially acceptable drug that was addicting only for some people, who were born alcoholic and would become powerless when they eventually consumed it: traces of degeneracy discourses also seem present in this construction. AA could help such people abstain and *recover*, although never be cured, by applying its 12 Steps (Duff Gordon, 2017; Fox, 2015). These focused on facilitating a spiritual and behavioural transformation, in a seeming repetition of the paradox of inebriety treatment: the alcoholic's will was the source of his or her illness, and recovery involved accepting this powerlessness. But the alcoholic had to want to recover, which necessarily required engaging the will to remain abstinent.

This normative and governmental discourse thus privileged the liberal self by constituting recovery as the reinstitution of self-control. It produced a new subject, the recovering alcoholic, who again seemed to be rendered childlike through his or her lack of willpower (Duff Gordon, 2017). Interestingly, though, this subject was not inferior to medical authority, at least ostensibly. Addiction was self-diagnosed in the first Step. And treatment was exclusively predicated on the alcoholic's active participation in recovery. This left no space for the application of medical knowledge. AA's structures also required neither a professional presence, nor a medical space

(Elam, 2015; Levine 2015). However, AA discourse also exhorted its subjects to govern themselves, and seemed to exemplify the mechanisms of the psy-complex (see section 2.2). It was subsumed by the medical profession, and became the dominant psychiatric treatment approach for alcohol addiction in the US (Duff Gordon, 2017).

Concurrent with the emergence of AA discourse, new psychological theories of addiction emerged in the form of psychoanalytic models (e.g., Glover, 1932; Radó, 1933). These emphasised the addict's regression to an early life developmental trauma, to which the he or she responded with substance use. This discourse also produced a childlike addict, unable to regulate or cope with his or her own experience and thereby deficient in willpower. However, here this addict was reliant on a paternal and strong-willed psychoanalyst, for treatment. This discourse, I argue, repeated the power relations of psychiatric mental illness discourse, and Rush's model of addiction.

2.3.6.2 *Withdrawal and tolerance.*

As the twentieth century progressed, new addiction discourses emerged based around physiological symptoms of tolerance and withdrawal. As addiction markers, these held promise of a path to scientific respectability for the field, because they were specific, identifiable and unreliant on theories of underlying characterological deficit. Within the withdrawal paradigm, substances that produced these symptoms were considered addictive, and those that did not were denied this status (Weinberg, 2013). Treatment was aimed at rapidly treating physical withdrawal symptoms and then promoting abstinence through "a system of moral enlightenment…to inculcate self-control and restore values more in line with conventional society" (Hill et al., 2016, p. 31). Despite these discourses' ostensible value-freedom, addiction treatment

was still constituted in moral and normative terms. They produced a weak-willed addict, who could only regain self-control under medical supervision.

2.3.6.3 *Drug addiction and the war on drugs.*

Medical addiction discourses continued to be unstable throughout the 1950s. The World Health Organization repeatedly redefined drug addiction. A 1950 definition emphasised the compulsion to increase drug use, along with physical and psychic dependence and detrimental effects on the user and society. But because some drug users did not follow this pattern, it was soon redefined as *drug habituation* and the allusions to compulsion and social consequences were dropped. In the next decade, drug habituation was replaced with a looser definition of *drug dependence*, characterised simply by psychic and / or physical dependence (Reinarman & Granfield, 2015).

Despite this confusion, in the early 1960s the British government reconfirmed the medical treatment of drug addiction, which was defined as "an expression of mental disorder" (Mars, 2012, p.7) rather than a criminal behaviour. It also issued the first guidelines for specialist psychiatric inpatient alcohol treatment. This treatment was based on the AA model (Thom & Berridge, 1995). Addiction was constituted as a psychiatric problem, and the psychiatric profession had now regained control over both alcohol and drugs. The interests of the state and medicine had realigned.

However, the ensuing decade's profound social changes and massive increase in recreational drug use within Western societies (Hendrickson, Schmal & Ekleberry, 2004), engendered a significant discursive turn. In a repetition of the Gin Crazes (see section 2.3.1), the British government responded to this apparent threat to society by tightening control over drug prescriptions and, in the early 1970s, introducing new prohibitionist and criminal legislation (Mars, 2012). In the US, the Nixon administration initiated the *war on drugs*.

Against this backdrop, in 1972 the American Psychiatric Association (APA) introduced the concept of *drug abuse*, defined as non-medical use of consciousness-altering drugs in ways that "are considered by social norms and defined by statute inappropriate, undesirable, harmful…or culture-alien" (Zinberg, 1984, p. 39): this medical definition was reliant on social and legal norms. It produced the drug abuser, as much a criminal as a patient, who seemed to threaten the very fabric of society. Indeed, the US government constituted this drug abuse as *America's public enemy number one*, enacted broad legislation to criminalise drugs, and in 1974 founded the National Institute of Drug Abuse (Sacco, 2014). This established separate funding and research streams for addiction and mental health, leading to the development of separate treatment programmes (Hendrickson et al., 2004). Reinarman and Granfield (2015) have noted a striking circular productivity between medicine and the state, here: lawmakers justified new drug laws on the basis of medical expertise, but this medical expertise was contingent on legal terminology. Addiction, I argue, continued to be a locus for fears about societal change. Moreover, these fears initiated a discursive differentiation of mental illness and addiction, which would make dual diagnosis possible.

War on drugs discourse has become hegemonic, and shapes policy and public opinion about drug use and addiction (Orsini, 2017; Rosino & Hughely, 2017). Mountian (2013) has applied a Foucauldian disciplinary lens to this discourse, which has become increasingly prevalent in Britain. In constituting drugs as "the engine of crime" (p. 57) it produces drug using subjects as deviants, in an apparent echo of degeneracy discourse (see section 2.3.4). It also objectifies drugs and drug users as a poorly defined *enemy*. This is strategically useful, because this enemy can cause fear precisely because of its polyvalent qualities, and this objectification can be deployed towards substances or social groups according to need. The enemy is also imbued

with extraordinary power, and positioned as coming from beyond society's borders (Mountian, 2013).

War on drugs discourse is therefore a potent dividing practice that constitutes drug use in binaries of health and deviance and even life and death, as the slogan *say no to drugs, yes to life* illustrates (Mountian, 2013). In working drugs up as incontrovertibly bad and worthy of opprobrium, it gives rise to vigorous disciplinary projects of confinement and exclusion. Activities against drugs and drug users are sanctioned that would otherwise be socially resisted. Its disciplinary gaze is strengthened because "anyone has the moral power to intervene in other people's use of drugs" (Mountian, 2013, p. 81).

This discourse thus constructs drugs and drug users as an existential threat, "the antagonistic drug Other" (Crick, 2012, p. 408). Its narrative of virulent harm creates a sense of panic and emphasises the need for action, thereby facilitating dominating top-down power relations (Alexandrescu, 2014; Van Dijk, 2008). This may be evident in McKeown's (2010) description of dual diagnosis as "arguably one of the most significant problems facing health services" (p. 3).

2.3.6.4 ***Methadone treatment and psychological models of addiction.***

The war on drugs' impact was evident in the development of methadone treatment. This was introduced in America in the early 1970s, in response to rising heroin use and its perceived connection with a crime increase, and the return of heroin-using conscripts from the Vietnam War (Berridge, 2012; Fox, 2015). Heroin users' withdrawal symptoms were problematised as the cause of this criminality. It was theorised that substituting heroin for the legal methadone would eliminate these symptoms and crimes (Fox, 2015).

Methadone treatment established distinct treatment regimes for heroin and alcohol addiction, which made strikingly divergent assumptions about their patients,

with concomitant power effects (Fox, 2015). As noted above (see section 2.3.6.1), alcohol treatment assumed people could deploy their willpower to resist the temptation to drink, and renew this every day. Methadone treatment, by contrast, assumed its patients had no such resources: it involved substituting one addictive substance for another, to stop them committing crime. This produced a markedly different subject, the feckless heroin addict. Most of those in this treatment were from the working classes (Fox, 2015). While the alcoholic and heroin addict were both medicalised subjects, this medicalisation inscribed them in strikingly different ways. These treatment regimes, and their underlying assumptions, seemed to emulate the two-tier inebriety treatment (see section 2.3.4).

Furthermore, methadone treatment necessarily involved professional medical involvement to dispense the drug. Clients rarely participated in dosage decisions, and had to submit to drug screening on pain of treatment termination. Heroin addiction was thus treated in a "quasi-medical, quasi-criminal arrangement" (Fox, 2015, p. 161). In Britain, compulsory methadone treatment was instated, and continues today. It could be argued that it was a disciplinary regime, while alcohol treatment was an example of governmental power.

Throughout the next decade new psychological models of addiction developed, based on *social learning theory* (Bandura, 1977), which privileged expectancies of the capacity to control drug use. These developed through past social experiences. Positive past experiences of controlling behaviour would engender strong coping expectancies, and afford the capacity to keep substance use within socially acceptable levels. Addicts, by contrast, had "poor coping skills in general for dealing with life's problems" (Jung, 2010, p. 31), and turned to substances to manage these problems. These models constituted addicts as incapable of managing themselves adequately, once again, and reliant on psychologists for help. Within this paradigm, Akers (1985) constituted addiction as a deviant behaviour, learned through

socialisation with deviant role models (Ford & Ong, 2014). This normative model, I argue, resourced war on drugs discourse and produced a similarly quasi-criminal drug addict. It seemed an effective dividing practice.

2.3.7 Addiction and the Diagnostic and Statistical Manual of Mental Disorders.

In the 1970s the APA attempted to address the persisting problem of diagnostic unreliability in psychiatry, which was a serious threat to its status as a medical science (Davies, 2013). In 1980, it published the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III; APA, 1980). This was designed to be a standardised diagnostic system based on specific categories of mental disorder, identified by observable and reportable symptom clusters. The diagnostic categories specified inclusion and exclusion criteria, to promote inter-rater reliability (Fraser, Moore & Keane, 2014; Nathan et al., 2016; Scull, 2015). Discursively, this was highly productive. Diagnostic categories created clinical cutoffs that produced new subjects of psychiatric knowledge in dichotomies of health and illness. DSM-III was a formidable tool of psychiatric power, as a dividing practice. Davies (2013) has detailed the use of political consensus in the development of DSM-III's diagnostic categories. Its claims to value-free scientific status were seriously overstated.

DSM-III had a separate chapter for *substance use disorders*. This formalised the discursive segregation of mental illness and addiction, which the state had begun a decade earlier (see section 2.3.6.3). It made a dual diagnosis of addiction and mental illness possible, for the first time. These disorders were applicable to a range of substances including alcohol, opiates, amphetamines, cocaine and cannabis.

The chapter distinguished substance abuse and dependence. These disease constructs continued to rely on moral judgements. Substance abuse was classified by

the normative criteria of pathological use and a resultant social or occupational impairment. A minimum one month time course was specified. Substance dependence was diagnosed by the presence of withdrawal symptoms, except with alcohol and cannabis where evidence of social or occupational impairment was also required. (Fraser et al., 2014; Nathan et al., 2016). In DSM-III-R (APA, 1987), loss of control, the core component of Rush and Trotter's original disease construction of addiction (see section 2.3.2), was included as a criterion for substance dependence (O'Brien, 2011).

In DSM-IV (APA, 1994), the chapter was renamed *substance-related disorders*. This reflected what Nathan and colleagues (2016) have described as "a broader purview" (p. 43), through which more substances were classified as addictive, including caffeine, sedatives and hypnotics. Substance dependence was also redefined. It no longer required tolerance or withdrawal for positive diagnosis. This reflected evidence that some drug users used compulsively without developing withdrawal symptoms, and others developed withdrawal symptoms without compulsive use (Nathan et al., 2016; Weinberg, 2013). Withdrawal, which had previously held the promise of scientific respectability (section 2.3.6.2), began to destabilise addiction. New discourses were needed to reaffirm its credibility. These emerged in constructions of addiction as a chronic and relapsing brain disease.

2.3.7.1 *The brain disease paradigm and DSM-5.*

Brain disease discourses are based on developments in imaging technology that show the brain responds to psychoactive substances in similar ways to other pleasurable activities. This has led to the hypothesis that such substances hijack the brain's natural reward pathway (e.g., Kalivas & Volkow, 2005; Koob & Volkow, 2010), leading to structural changes that explain their addictive nature. These neurobiological processes are constructed as causal mechanisms, and assumed to

underpin all the addictive disorders in DSM-5 (APA, 2013). This has stabilised the disease construct of addiction "as (an) observable neurobiological condition" (Fraser et al., 2014, p. 30). Such discourses are now preeminent in psychiatry, and facilitate novel biological constructions of mental illness (Scull, 2015). Vrecko (2010) has linked the emergence of these new discourses to the Nixon administration's war on drugs, through which research that conceptualised addiction as a biochemical disorder was funded: these discourses represent an ongoing harmony of the interests of medicine and the state.

DSM-5 (APA, 2013) contains a chapter entitled *Substance-Related and Addictive Disorders*. This title effectively untethers addiction from substances and opens space for behavioural addictions. The brain disease paradigm provides support for this discursive decoupling: brain scans reveal that a wide range of human behaviours can produce the responses identified in relation to psychoactive substances (Reinarman & Granfield, 2015).

DSM-5 conceptualises a new core syndrome of *substance use disorder*, which subsumes the previous categories of substance abuse and dependence. It additionally affords a dimensional diagnosis. From the disorder's eleven diagnostic criteria, the presence of two or three indicate a mild case, four to five a moderate one, and six a severe presentation. Moreover, these symptoms can have appeared at any time in the past year (Fraser et al., 2014). Thus this new syndrome's diagnostic criteria are less specific, relevant over a longer period of time and require a lower threshold for positive diagnosis. It produces more addicts than previous iterations. Loss of control remains a core criterion, and craving is also reintroduced. Both are identified by self-report. These self-report measures seem to demonstrate the workings of the psy-complex, again (see section 2.2): as with AA discourses, to be an addict one must first declare oneself an addict.

DSM-5 has been heavily criticised for systematically over-diagnosing behaviour, aided by the undue influence of drug companies (Nathan et al., 2016). Brain disease discourse has also been critiqued. In claiming that drugs corrupt the brain's natural reward pathway, addicts are recast as hostages to this brain hijack. This effectively problematises these drugs, in a continuation of earlier *demon drink* and *possession* discourses (Room, 2015). Vrecko (2016) has also noted how constituting addiction as a chronic disease leads to relapse becoming its main feature. In this discourse, relapse is the consequence of craving. And craving is constituted as the result of a combination of factors including genetic susceptibility—calling to mind earlier degeneracy and inebriety discourses—and prolonged exposure to the drug of choice (Elam, 2015). Thus, I argue, the current chronic relapsing brain disease discourse synthesises historical medical and temperance constructions of addiction, and problematises both the substance *and* the person. Perhaps this accounts for its stability. Furthermore, constituting addiction as a chronic disease means that recovery remains a matter of personal responsibility, and continues to involve the rigorous application of self-control. Thus, this neurobiological addiction discourse provides "new technoscientific grounds for a remoralisation of disease" (Elam, 2015, p. 49). It is perhaps unsurprising that the proponents of this discourse who argued it would destigmatise drug use and challenge prohibitionist policies, have been proved wrong (Fraser et al., 2017).

This paradigm again embodies the circular productivity of psychiatric discourse (Foucault, 2000c; see section 2.2). Discourses of addiction as a disease affecting the brain—either functionally or structurally—have existed for at least a century (see section 2.3.4). Technological advances have led to the development of brain scans, deployed as tests that confirm this truth claim, through which psychiatry's scientific status is affirmed and enhanced.

In conclusion, DSM constructions of addiction have proved highly unstable over the past 40 years; as have its constructions of mental disorders generally (Scull, 2015). Criteria such as self-control and withdrawal have been introduced and dropped. Yet at the same time, addiction has proved resilient. Unlike other disease constructs, it has become more flexible and less specific over time (Reinarman & Granfield, 2015). This has facilitated its application to ever increasing areas of experience, bringing them under medical purview. Contemporary neurobiological discourses also seem to problematise substance and person simultaneously. Consequently, they constitute addiction as a more nefarious disease, demanding constant vigilance and self-control to defend against it. These discourses are potent governmental tools.

Over the past twenty years increasingly complex psychological models of addiction have proliferated, which mobilise these DSM discourses. For example, West and Brown's (2013) *synthetic theory* constructs addiction as resulting from abnormalities in a neurological motivational system. These abnormalities may result from changes induced by a behaviour or substance—thereby mobilising possession discourses—or from a pre-existing internal brain abnormality such as depression or chronic anxiety: this problematies the addict. Orford (2001) has constituted addiction as an underlying problem of *excessive appetite*, which may affect a swathe of activities including substance use, gambling, eating and sex. These appetites develop gradually, through social learning (see section 2.3.6.4). An appetite is considered excessive when it erodes freedom of choice: addiction thus remains a liberal disease. Moreover, this discourse strikingly resembles the original constructions of mental illness and addiction as diseases of excess passion and desire.

2.3.8 The recovery movement.

In response to the dominating power dynamics of the above medical discourses, an alternative—or competing—recovery discourse emerged in the 1980s. This developed independently in the mental health and addiction fields (Roberts & Bell, 2013). In the former, it was an outgrowth of the psychiatric survivor movement (Crossley & Crossley, 2001; Resnick & Rosenheck, 2006). In the latter, recovery discourse arose as a legacy of treatment approaches such as AA, which emphasise lived experience and peer support (Roberts & Bell, 2013)—although Berridge (2012) has argued the term is also "redolent of 19th-century temperance" (p. 22).

In both contexts, recovery discourse's emergence was also propelled by a growing recognition of the need to combat stigma in practice (Roberts & Bell, 2013). Indeed, recovery-focused treatment is partly constituted as a recovery from stigmatisation. This model has become a core concept in British mental health and substance use policy and practice. It enjoins practitioners to be aware stigma's impact, and commit themselves to non-stigmatising practice (e.g., Leamy, Bird, Le Boutillier, Williams & Slade, 2009; NICE 2011, 2016).

This discourse posits recovery as an individualised process, which engenders a reorganisation of power arrangements between practitioners and clients (Slade, Adams & O'Hagan, 2012). Fardella (2008) has argued that it affords "a critical retrieval by the subject of herself as self-determining agent of change" (p. 111). However, scholars have noted contradictions, here (e.g., Fomiatti, Moore & Fraser, 2017; Lancaster, Duke & Ritter, 2015). While recovery is constituted as living with disorder as fully as possible in mental health contexts, in the substance use field it entails moving beyond addiction. For example, the UK Drug Policy Commission (2008) defines recovery as "characterised by voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society" (p. 6). This highly governmental definition

evokes an ideal liberal subjectivity, in contrast to a life on drugs (Lancaster et al., 2015). More recently, recovery has been explicitly associated with abstinence (Home Office, 2017). Recovery may therefore simultaneously signify an individualised and a prescribed process.

Moreover, Rose (2014) argues that it is "shot through with...normalisation" (p. 217). Indeed, the expert addiction literature constructs recovery as a process of identity change, made possible by ceasing aberrant drug use and participating in normal activities (Fomiatti et al., 2017); as the UK Drug Policy Commission's above definition seems to illustrate. Reith (2004) has contested the claim that recovery can facilitate the development of this new liberal identity, because a recovering addict identity is as adhesive as that of the addict. Both mark out the subject as not free to choose, thereby denying him or her genuine liberal subjectivity.

2.3.9 Conclusion to a genealogical approach to addiction.

The history of addiction over the past 200 years is not one of progress but of a repetition and reaffirmation of its initial construction by Rush and Trotter, and its attendant moral judgements and power relations. While addiction has at times been contested by the medical profession and the state, the past 50 years has seen an increasingly cooperation and interconnection in this area. This is evident in the discursive production of the heroin addict, and this figure's subjection within a totalising network of medical and legal judgements and power relations. There seem echoes in this process of the production of the female inebriate a century earlier. And as with inebriety discourse, contemporary medical discourses of addiction are applied today in different ways to different groups, with different power effects.

Contemporary addiction disease models presuppose a proper non-addicted person who successfully regulates behaviour through making rational decisions (Fraser et al., 2017). This is the same liberal citizen who made addiction possible in

the first place, some 200 years previously. In contemporary Western economies, the state has increasingly withdrawn from the regulation of everyday life while mass consumption through immediate gratification is increasingly encouraged (Reinarman & Granfield, 2015; Reith, 2004). These contradictory expectations have enhanced the importance of self-regulation: "the burden of liberty" (Reith, 2004, p. 296) has only increased.

In this context, the figure of the addict as *consumed* by consumption assumes an even greater cautionary relevance. The addict has failed to manage this liberty effectively, and as a result has forfeited his or her autonomy and choice. Unlike the self-regulating citizen who is free to assume other identities, the addict is stamped with this label, and is expected to carry it even in recovery: this seems to undermine recovery discourse's liberatory potential. Indeed, this label is readily self-applied in this process. The addict is the living example of a failure to self-regulate, and a constant reminder to maintain this self-control. This figure is a particularly effective example of governmental power, guiding the conduct of the populace's conduct.

2.4 A Genealogical Approach to Dual Diagnosis

In one sense, the history of dual diagnosis as a discursive phenomenon is brief. As noted above (see section 2.3.7), it was only with the publication of DSM-III that co-occurring psychiatric diagnoses became possible, and the term is rooted in this theoretical segregation of mental health and substance misuse disorders. It arose to identify people within mental health or substance misuse services who now also had a diagnosis that was treated by the other system (see section 1.2). According to Hendrickson and colleagues (2004) the term was "borrowed from the mental retardation field" (pp. 25-26): this itself is a medico-legal term arising from nineteenth century psychiatric discourses and dividing practices (Foucault, 2000a).

Perhaps this choice of term may also indicate implicit judgements about the capacities of the group it was intended to designate.

As discussed (see section 2.3.6.3), while DSM-III formalised the clinical segregation of mental health and substance use problems, this process began a decade earlier in the US government's response to the social changes and increase in recreational drug use during the 1960s. This response established separate research, funding and treatment streams for mental illness and addictions. It was followed during the 1970s and 1980s by frequent observations that psychiatric patients also admitted using drugs (McKeown et al., 1998), which in turn repeated nineteenth century psychiatrists' observations that many asylum patients had used alcohol to excess (McCandless, 1984).

Thus, after the state enacted the discursive bifurcation of mental illness from addiction, medicine soon rediscovered their frequent co-occurrence. This led the medical profession to produce a new discourse to explain this phenomenon. This new discourse also triggered a series of scientific papers through which dual diagnosis was legitimized (McKeown et al., 1998). The state's response, as characterised by Nixon's war on drugs, was also in part a moral undertaking. Dual diagnosis, then, is the product of political, legal, and moral processes that were themselves a response to fears raised by rapid social change. This is a repetition of the discursive production of addiction in the nineteenth century, and mental illness a century before that. Indeed, dual diagnosis discourses seem inflected with moral panic, as its description by the UK government as one of the largest problems facing mental health services (DoH, 2002) may indicate.

While mental illness and substance use had hitherto been considered interrelated—and had similar historical and moral roots—a division of their treatment had occurred previously with the establishment of the inebriety asylums. Smith (2010) cites the Superintendent of Gartnavel Royal Hospital in Glasgow, who in

giving evidence to parliament in 1895 in support of these asylums claimed that "respectable lunatics do not care to be associated with a man who is just a demoralised drunkard and I think in their interest he ought not to be there" (p. 355). Perhaps there are echoes here of the need to protect prisoners from defilement by the mad, which partly motivated the establishment of the first psychiatric asylums (see section 2.2). Moreover, the derogation of substance use problems in relation to those of mental health continues with dual diagnosis, which as discussed above can frequently lead to exclusion from mental health services due to ongoing substance use (see section 1.2). Indeed, Roberts and Jones (2012) argue that dual diagnosis "invokes the moral concept of the deserving or undeserving sufferer" (p.673).

Dual Diagnosis began to appear as a concept in Britain in the 1990s, by which time it had lost its inverted commas and had thereby "assumed an established concreteness" (McKeown et al., 1998, p. 67). This seemed to demonstrate its constitution as a medical discourse. By the middle of the decade the government had begun to commission research, which reported massive increases in dual diagnosis rates in primary care, mental health and substance use service settings (Hill et al., 2016). Shortly after the emergence of dual diagnosis discourses in the UK, then, this new problem was found to be everywhere: McKeown and colleagues (1998) have argued that this construct is paradigmatic of the psy-complex.

The UK government soon responded through the Task Force Review (DoH; 1996) and the Dual Diagnosis Good Practice Guide (DoH, 2002; see section 1.2), which attempted to establish standards of practice and models of service. Specifically, they advocated integrated support for mental health and substance use within psychiatric services. The medical profession, in the form of NICE, has also produced guidelines for practice with dual diagnosis clients (e.g., NICE 2011, 2016). There seems to be a harmony between medicine and the state with dual diagnosis, through

which a new disease has been identified and confirmed, and those so affected brought under their control.

Dual Diagnosis discourses have been increasingly widely deployed in UK health settings. However, as noted above (see section 1.2) a feature of these discourses is the lack of consensus over its definition. It too is an unstable discursive phenomenon. It has been criticized both for being so over-inclusive it is rendered meaningless (McKeown et al., 1998), and for being too restrictive in establishing an arbitrary and exclusive threshold for treatment (Velleman & Baker, 2008). Indeed, the latest NICE (2016) guidelines seem to establish such a threshold through referring to dual diagnosis as "coexisting severe mental illness and substance *misuse*" (p. 5; emphasis added). This definition seems to illustrate the normative and moral assumptions within this construct. Substance use services, by contrast, have constructed dual diagnosis much less narrowly (Roberts and Jones, 2012). As discussed above (see section 1.2) this discursive instability may shed light on the current confusion about effective psychological treatments for dual diagnosis, and its prevalence.

Although current constructions of dual diagnosis and addiction both lack specificity, they seem to produce divergent power effects. Neurobiological discourses seem to facilitate the spread of addiction and the medical gaze over ever-wider areas of human experience. But ascriptions of dual diagnosis can often lead to exclusion from mental health services. Moreover, this exclusion is justified in terms of the inability to achieve abstinence. The dual diagnosis client's self-control is again problematised in this condition. It seems, indeed, that both narrower psychiatric constructions and broader substance use service constructions may justify exclusion. The former creates a high threshold for treatment, while the latter problematises a swathe of clients, whose needs then cannot be met by drug services. High rates of poverty, homelessness and marginalisation have also been reported among dual

diagnosis clients, who have been described as a "mental health underclass" (Hawkings & Gilburt, 2004, p. 57). Perhaps implicit class-based assumptions about willpower are also present in these exclusions.

2.4.1 Conclusion to a genealogical approach to dual diagnosis

Dual diagnosis is paradoxically a scientific discourse with no agreed scientific definition. Its lack of specificity and inconsistent construction in different health services seems to justify exclusion from care on a large scale. Indeed, dual diagnosis may presently be a discourse of exclusion. The confusion of dual diagnosis discourses produces a similarly confused dual diagnosis client. This figure transforms, depending on the health setting. Foucault (2000a) described the medieval juridico-moral figure of the *monster* that, he argued, lay behind nineteenth century psychiatric discourses of abnormality (see section 2.3.4). This monster was a "double violation" (p. 51) of the laws of society and nature, and combined what was thought impossible and forbidden in the same form (Hook, 2007).

Perhaps the dual diagnosis client may represent a contemporary incarnation of this monstrous figure. This client, as a figure with both a mental health and substance misuse problem, embodies a double violation of self-control—and thus of morality—in a hyper-governmental age that demands its perpetual application. The dual diagnosis client is thus forbidden, in these terms.

This figure may also combine what is discursively impossible. It transgresses the discursive bifurcation of mental health and substance use service provision in the UK, and fits within neither. Like the monster, the dual diagnosis client is thus "a breach of law that automatically stands outside the law" (Foucault, 2016, p. 56): by transgressing the discursive regimes of truth, he or she is excluded from them. Butler (1993) has argued that "the force of exclusion and abjection" (p. 3) is critical to the constitution and circumscription of the subject. Dual diagnosis clients' exclusion may

therefore simultaneously a means of social production, through which the contemporary liberal subject—rational, autonomous, and sober—is formed (Fraser et al., 2017). By their transgression of the behavioural norms associated with this subjectivity, dual diagnosis clients are not merely excluded from services but denied the status of liberal subjects. Indeed, their paradoxical subjection as non-subjects seems to justify and render their exclusion intelligible.

Dual diagnosis clients' monstrosity—or non-subjectivity—can further explain why these clients are the objects of stigmatisation by mental health professionals and may feel disempowered in their interactions with them (e.g., Avery et al., 2013; Chorlton et al., 2015; Ralley et al., 2009), why these professionals may also feel confused or deskilled with dual diagnosis clients (e.g., Adams, 2008; Coombes & Wratten, 2007), and why integrated dual diagnosis care remains the exception, rather than the rule (All Party Parliamentary Group on Complex Needs and Dual Diagnosis, 2014; Schulte et al., 2008). It may also explain why the dually diagnosed are significantly over-represented in the prison population, along with the mad (Prison Reform Trust, 2011; Scull, 2015). Indeed Scull (2015) argues that we have come full circle here: the mad and the dually diagnosed are parts of an undifferentiated population existing at the very margins of society, and in its prisons. These are the very conditions which gave rise to psychiatry, some two hundred years ago. Ironically, I argue that these conditions could now be the result of the state and medical profession working in concert, united in their disapproval of the dually diagnosed. As noted above (section 1.2) the Dual Diagnosis Good Practice Guide (DoH, 2002), which was product of medicine and the state, eschewed defining dual diagnosis. This may then have facilitated the discursive confusion and culture of exclusion that characterises dual diagnosis practice today.

Chapter Three

Methodology and Method

"Knowledge is not made for understanding; it is made for cutting"

(Foucault, 1971/1991, p. 88)

3.1 Introduction

In this chapter, I will describe the poststructuralist research method that I used to investigate the research question; *"What are the discursive power relations in practitioners' accounts of working therapeutically with dual diagnosis clients?"*. First, I will locate the FDA adopted in this research within the broad field of psychology, and then specifically in the discipline of counselling psychology. Next, I will outline the methods I deployed to collect and analyse this study's data, in accordance with ethical guidelines. Finally, I will discuss issues of reflexivity as a researcher, and the criteria of quality that are applicable to this qualitative research method. These criteria will be used to evaluate this research in Chapter Five.

3.2 FDA and Poststructuralist Epistemology in Psychology

As discussed in Chapter One, from a poststructuralist perspective reality and meaning are socially constructed and historically located, and discourse is the medium through which this is achieved (Gergen, 2015; Potter & Hepburn, 2008). As discourse is productive and power-laden, it is an object of study, itself. This research thus aims to illustrate the power relations in ten dual diagnosis practitioners' accounts of working therapeutically with dual diagnosis clients, to raise awareness for CoPs of the power effects that may be at play in working with this client group, and their implications for clinical practice.

In contrast to traditional psychology's positivistic and realist claims of representativeness and objectivity, discourse analysis (DA) in psychology is informed

by a poststructuralist epistemology that posits the ubiquitous barrier of language as opaque and strategic. DA is a wide-ranging group of research methods, which focus on the study of context-bound, constructive and functional language in use (Avdi & Georgaca, 2007; Nikander, 2008). Currently, the two most popular DA approaches in contemporary psychology are discursive psychology (DP), and FDA (Willig, 2013). It is useful to compare these two approaches to clarify my chosen methodology of FDA: although it should be noted that while Parker (1992, 2013) and Willig (2013) have highlighted their differences, others have identified their shared assumptions, not least a methodological relativism that eschews *a priori* assumptions about the truth or relevance of one account over another (Potter & Hepburn, 2008; Potter & Wetherell, 1995).

Burr (2003) describes DP as a *micro-constructionist* approach that focuses on a detailed analysis of the function of talk in negotiating agency and accountability. From this *bottom-up* perspective, people are viewed as skilled and agentic users of language, through which they accomplish effects and manage their own interests. DP therefore focuses on the *action orientation* of participants' talk. Moreover, DP only attends to features of discourse that participants themselves demonstrably orient to: power is discussed only insofar as participants may refer to it in their accounts (Nikander, 2008; Potter & Hepburn, 2008). For example, Askew (2016) used this method to illustrate how participants legitimised illicit drug use by rhetorically deploying three distinct discursive frameworks: a "drug cultures" framework that highlighted the accommodation of drug use within social networks; a "planned celebration" framework that legitimised use through infrequent consumption; and a "situational opportunity" framework that emphasised the wide availability of illicit drugs as a determinant of behaviour.

FDA, by contrast, is a *macro-constructionist* approach that investigates how broader cultural and institutional discourses determine and are called upon in the

construction and negotiation of accounts (Avdi & Georgaca, 2007; Burr, 2003). From this *top-down* viewpoint the constitutive power of language is prioritised, and the wider socio-political influences and apparatuses that produce and constrain people as subjects is examined: FDA presupposes a markedly weaker actor than DP (Jones, 2017; Miller, 2008). As noted above (see section 1.6), FDA was introduced to psychology to challenge the assumptions of mainstream psychology. For example, Rose (1998) and Parker (1999) have used FDA-informed research to critique psychological knowledge and its institutions, and highlight psychology's social regulative effects. FDA's top-down perspective has also led to criticisms of its diminished clinical relevance (Avdi & Georgaca, 2007). However, Hodges (2002) has demonstrated its value to practice through his analysis of interactions between radio counsellors and the public, which illustrated both how clients were constructed in these interactions and how this legitimised and perpetuated psychotherapy's institutional position of power.

I considered DP for this research. But in light of its aforesaid research question, which was informed by the apparent relations of power in the literature, FDA is argued to be the appropriate method. This is because of its explicit concern with these power relations, and its illustration of how participants' accounts draw on social, cultural and institutional discourses that bring 'realities' into being, constitute subjects and facilitate certain experiences while foreclosing others (Duff Gordon, 2017; Willig, 2013). In short, FDA highlights how participants are talked by the language they use (O'Callaghan, in press). Therefore this research's epistemological assumptions are guided by poststructuralism's extreme relativist perspective, from which "the world is like a text: it *all* has to be represented and interpreted (Edwards, Ashmore & Potter, 1995, p. 33). The analysis I present below is therefore only one of many possible readings of the data.

While it is acknowledged that Foucault did not prescribe a method for conducting FDA, describing his works instead as "a kind of toolbox which others can rummage through to find a tool which they can use however they wish in their own area" (Foucault, 1974, pp. 523-524), psychological researchers have proposed various guidelines for conducting this form of analysis (e.g., Arribas-Ayllon & Walkerdine, 2008; Hook, 2007; Parker, 1992; Willig, 2013). Arribas-Ayllon and Walkerdine (2008) have summarised three broad dimensions of FDA that are of interest to psychologists (Randol, 2014). First, since FDA is historical in its concern with how discourses come into being and are sustained (Hook, 2007), they assert the importance of conducting a historical inquiry of the specific topic. I have done this in the genealogy offered in Chapter Two. Second, the analysis should be focused on the mechanisms of power operating between discursive objects and subjects. I address this in my problematisation of dual diagnosis (Chapter One), genealogy (Chapter Two), and the analysis provided in Chapter Four. Finally, FDA should be concerned with how people are made subjects through discourses, and the practices through which they are so positioned. This is the principle focus of my analysis in Chapter Four. It is argued that this is relevant to counselling psychology because of its aforesaid interest in issues of power and language, in practice (see section 1.3).

3.3 Methodological Design

This research elicited participants' accounts of working therapeutically with dual diagnosis clients by means of semi-structured interviews with an opportunity sample of ten psychological practitioners. Such interviews are a common and pragmatic way of collecting relevant data for analysis (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013). Numerous recent FDA studies have employed this data-collection technique, which indicates its capacity to collect sufficiently rich data (e.g., Buckland, 2016; Gent, 2017; Hanna, 2014).

3.3.1 Ethics.

This research was approved by the University of Roehampton's Ethics Committee (see Appendix A). It adhered to the BPS's Code of Ethics and Conduct (BPS, 2018), and Generic Professional Practice Guidelines (BPS, 2008).

It additionally conformed fully to the Data Storage Protection Guidelines of the University of Roehampton's Centre for Research in Social and Psychological Transformation (see Appendix B). All collected data were treated confidentially and anonymously. Participants were given a pseudonym and all identifying information was removed from the data during transcription. Transcripts and audio-recordings have been securely stored according to data protection law, and will be destroyed after ten years in accordance with BPS Ethics (BPS, 2018).

Participants were required to read and sign an informed consent form (see Appendix C), which was securely stored in a locked filing cabinet, separate from research data. The consent form notified participants of their rights, including confidentiality, and their freedom to withdraw from the research. On conclusion of their interview participants were also given a debrief form (see Appendix D) to ensure the interview had been conducted ethically. This form provided the researcher's contact details, and those for organisations that could be approached for support if participants experienced post-interview distress. No participants reported concern or withdrew consent.

3.3.2 Participants.

This research recruited ten participants via advertisement and snowballing. The research advertisements targeted third-sector organisations providing counselling services to dual diagnosis clients. These organisations were initially approached by sending a letter (see Appendix E), asking for permission to post an advertisement (see

Appendix F) to the relevant services. This research also directly approached practitioners working privately with a separate letter (see Appendix G).

For the purposes of FDA, this sample was considered sufficient. FDA seeks to interrogate the discursive resources mobilised by participants, and the power relations within their accounts, without seeking to generalise beyond the sample (Willig, 2013). Therefore, it requires a modest sample size to provide sufficiently rich data for the purposes of analysis. Randol (2014) and Jones (2017) have demonstrated how a sample of ten participants is sufficient for this approach.

This research's inclusion criteria specified that participants should self-identify as accredited psychological practitioners (e.g., BACP, BPS, UKCP, BABCP) with at least six months' experience of working therapeutically with dual diagnosis clients. This was considered sufficient time to have developed ideas and opinions about working with this client group. There were no criteria relating to gender or work setting, as FDA values all contributions and contests essentialisms associated with such social constructs. Furthermore, there were no inclusion criteria relating to therapeutic approach: as discussed above (see section 1.2), research has identified no evidence of any approach's superior efficacy with this client group (Hunt et al., 2013).

3.3.3 Procedures for data collection.

Following initial contact from potential participants, I issued the participant consent and debrief forms outlining this research's premise and requirement of a one-to-one audio-recorded interview expected to last no more than 90 minutes. I agreed a date and time to conduct the interview, at a convenient location. Participants were either interviewed at their workplace or the University of Roehampton. All interviews were conducted in a private room so participants could speak without interruption.

On meeting, participants signed the consent form, and were encouraged to ask questions or raise concerns. I issued participants a unique identification number to preserve anonymity and confidentiality, and stored the code linking this number to participants' pseudonyms in a locked cabinet, separate from any research data. I recorded interviews using an Olympus WS-831 digital voice recorder.

During interviews, I was guided by the following nine open questions:

- Can you tell me how you came to work with dual diagnosis clients?
- How did your training help to prepare you for work with this client group?
- How do you understand dual diagnosis as presently defined in health settings?
- How do you define dual diagnosis personally?
- In your work with dual diagnosis clients, what have you found most satisfying?
- In your work with dual diagnosis clients, what have you found most frustrating or difficult?
- How do you think the wider public perceptions of dual diagnosis (or drugs / alcohol and mental health) are at play in your work with dual diagnosis clients?
- Are there any other issues you have experienced that contribute to enhancing therapeutic work with dual diagnosis clients?
- What do you think the future may hold for dual diagnosis in therapeutic work?

I used these questions to access and highlight participants' constructions and truth claims about working therapeutically with dual diagnosis clients. While they provided a guide, I used them flexibly to engage participants, facilitate other questions, and clarify responses (Willig, 2013).

After the interview, I gave participants the debrief sheet and answered any questions or responded to any feedback about the interview. I then transcribed interviews using Malson's (1998) transcription conventions. This was appropriate to the present research because FDA is concerned with the content and use of language in participants' accounts, rather than the delivery of speech (Jones, 2017).

3.3.4 Steps in the analysis.

As discussed above, this research's central analytic interest was the contingent power relations in participants' accounts of working therapeutically with dual diagnosis clients. Willig's (2013) six-stage FDA model informed my analysis of participants' accounts. I additionally drew on Parker (1992), Hook (2007) and Arribas-Ayllon and Walkerdine's (2008) insights to further refine and develop this analysis.

The first step was immersion in the data. I read through and annotated each transcript several times to familiarise myself with content and themes that related to the research question. I initially focused on how the discursive objects of *dual diagnosis* and *dual diagnosis clients* were constructed in participants' talk. As argued in Chapter Four, participants resourced wider normative discourses of mental illness, drug use and addiction in their accounts. I therefore additionally considered how these broader discursive regimes underpinned and facilitated these constructions.

I then attended to the subject positions in participants' accounts. These provide "a location for persons within the structure of rights and duties" (Davies & Harré, 1999, p. 35) determined by the discourse that is resourced in talk. I analysed how practitioners, clients and other professionals were positioned by their accounts, and the power relations therein. Finally and most tentatively, I investigated how these subject positions seemed related to ways of experiencing and being in the world, and thus the consequences of participants' subject positioning on their subjective

experiences (Willig, 2013). This entailed examining the range of thought, feeling and experience facilitated by these subject positions.

In conclusion, these analytic steps aimed to afford insight into both the broader power relations in the circulating discourses that resourced participants' constructions of dual diagnosis and dual diagnosis clients, and the more local relations of power illustrated by subject positions and subjectivities. I considered this necessary to address the research question. Moreover, this research's poststructuralist perspective acknowledges that the below analysis is a product of both researcher and participant being subject to—and acting within—established networks of social, cultural and institutional meaning (Willig, 2013): indeed, qualitative research in general conceptualises the researcher as thoroughly embedded within the research process. Hence it is essential to include a consideration researcher reflexivity, both to acknowledge the interpretative nature of the research, and interrogate the implications of the researcher's involvement in the research process (e.g., Finlay & Gough, 2003; Morrow, 2005; Ponteretto, 2005). In the next section I explore such issues.

3.4 **Researcher's Reflexivity**

Reflexivity may be described as the process of "taking the researcher's self as an object of scrutiny and examining how this self, with all its cognitive, emotional and social parts, affects the research process" (Josselson, 2017, p. 119). Since reflexivity is engaged with in ways consistent with the researcher's epistemological and methodological position, it is important to consider both epistemological and personal reflexivity (Finlay, 2017; Finlay & Gough, 2003; Willig, 2013). I do so here, noting how the former impacts the latter.

As discussed above (section 1.4), a poststructuralist epistemology conceptualises a decentred and discontinuous self that is the product of power relations generated within and transmitted through discourse. This radically relativist

position additionally posits that reality is a discursive product: notions of truth and knowledge are disrupted and contested. From this stance, reflexivity does not—and cannot—reveal a researcher's hidden agendas or underlying motivations (Finlay, 2017). Reflexivity itself is a discursive and performative practice that contributes to shaping the researcher's role in and experience of the research. The researcher is also subject to the prevailing discourses of the topic of interest, which is itself a linguistic phenomenon. Researcher transparency is therefore impossible (Finlay, 2017; McSkimming, 2017).

Gemignani (2017) advocates a critical constructionist reflexivity that attends to the constructive and located nature of knowledge and resulting patterns of difference rather than an illusory description of essences and fixed positions. Reflexivity is thus "concerned with both constructions of the researched-researcher relation and the genealogical processes that guide such constructions, with the results of producing an entanglement of subject and object" (p. 194). This demands an openness to revisions of what one knows and assumes, and a consideration of the power relations of this knowing. For Gemignani (2017), such a reflexivity is a matter of ethics: as noted above (see section 1.5) Foucault (1991b, 1984/1992) also linked reflexivity to ethical self-formation, through facilitating a critique of the self that offers alternative ways of being. I employ this critical, constructionist stance in considering my personal reflexivity, which is understood as a response to the discursive practices to which I have been subject, and to which I may unthinkingly have subjected participants, in undertaking this research.

My initial interest in dual diagnosis lies in my own experience of persistent psychological distress and periodic substance use in adolescence and early adulthood. While the latter may initially have been an attempt to mitigate the former, for me they ultimately seemed to become entwined. These experiences no doubt contributed to my decision to work in a statutory substance use service before enrolling on the

PsychD at Roehampton. As a key worker, I was responsible for working with a small caseload of clients, with the explicit aim of facilitating a reduction in substance use.

I became familiar with the phenomenon of dual diagnosis, at this time. Clients with mental health diagnoses were so described within the service. Staff had often received little or no specific training for these diagnoses, so could feel deskilled—or perhaps intimidated—by them. They would try to refer these clients to local mental health services. However, mental health services would refuse to accept them until they were abstinent. These clients would often feel that this demand for abstinence was unrealistic and unreasonable. Thus, they would either return to the drug service, where staff did not feel competent to meet their needs, or drop out. The drug service also attempted to establish closer links with local mental health services, but this proved difficult. My colleagues perceived that mental health services were resistant to this, and they frequently voiced frustration about it.

Through working with my caseload I came to perceive that many of these clients seemed to be stigmatised not just by mental health services, but NHS services more generally. Most clients reported adversarial relationships with their GPs. Local pharmacies would refuse to allow these clients to collect their methadone prescriptions inside: they would have to wait at the back door, so as not to "put off" the other customers. Through my client work I developed a sense of injustice about the experience of dual diagnosis clients—and substance use clients more generally.

I enjoyed the environment of the substance use service. I found it disconfirmed some of my own assumptions about long term use of "hard" drugs. Several clients had also spent significant time in prison: in some cases, this was where they began to use substances. Again, my experiences with these clients raised my awareness about my assumptions about criminality, and discourses of substance users as dangers to society. These experiences also afforded me the chance to

challenge these assumptions, which in turn strengthened my sense of injustice about their place in society.

Many colleagues additionally self-identified as recovering addicts. This identity seemed extremely important to them. They would often take a cynical stance with clients, whom they perceived were unwilling to do the necessary work to overcome their substance use issues. I became curious about the apparent rigidity of this recovering addict identity, and its imposition on clients: rather than affording empathy, it seemed to have the opposite effect. This alerted me to the power dynamics of these identities and descriptions, and made me want to investigate them further.

Applying the aforementioned critical reflexivity to these experiences, while they made me more aware of normative discourses of addiction and substance use and my own assumptions regarding them, I also became subject to discourses of dual diagnosis clients' stigmatisation which were prevalent among my colleagues. The substance use service was itself located in a web of power relations arising from the discursive segregation of mental health and substance misuse problems. Consequently, the service itself seemed to function as a discursive practice.

These experiences therefore led to my constitution as an avowedly political and ideological researcher in the context of this inquiry. I located myself in a resistant position towards medical constructions thereof, and so within specific power relations that I have additionally transmitted to my participants by bringing this activist-researcher subjectivity to bear on our interviews. This was particularly true in my earlier interviews, before some of the discursive themes discussed in Chapter Four began to emerge. My ideological stance has shifted during this research. I will offer a further critique of my reflexivity in the context of my research findings in Chapter Five.

A critique of reflexivity itself is also warranted at this point. Counselling psychology prizes reflexivity, which is understood to help CoPs negotiate the multiple therapeutic and epistemological perspectives of its practice (Strawbridge & Woolfe, 2010). It has been incorporated as a professional competency (BPS, 2001). This could be argued to be a surveillance practice, through which CoPs regulate and form themselves according to the institutional norms embodied in counselling psychology training. The practice of reflexivity, then, may perform the very function it is intended to critique and counteract. As a discursive practice located within a web of power relations it must not be beyond contestation itself (Jones, 2017).

3.5 Criteria for Quality in Qualitative Research

The traditional quality criteria in quantitative research of validity and reliability are not appropriate or applicable to poststructuralist investigation. Indeed, from this perspective such terms are critiqued as rhetorical devices that may serve to legitimate scientific truth claims (Madill, Jordan & Shirley, 2000; Willig, 2013). By contrast, qualitative research's standards of quality focus on transparency and clarity of evidence from localised accounts that provide the reader with a rhetoric to consider the phenomenon under investigation in new and unexpected ways. In the context of counselling psychology, Morrow (2005) notes these as criteria of *trustworthiness.* She specifies three such criteria that span research paradigms and epistemological stances. The first criterion is *social validity*, which she relates to issues of researchers' subjectivity and reflexivity. I have addressed these above, and do so again in Chapter Five. The next criterion of *adequacy of data* was addressed through undertaking ten semi-structured interviews with psychological practitioners, through which saturation was argued to have been achieved: no new constructions or subject positions were revealed in the final interviews. I also attempted to ground the study in the culture and context of the participants through my own experience in substance use services

and my literature review and genealogy, which familiarised me with the setting and current state of dual diagnosis care in Britain.

This research addressed *adequacy of interpretation* through the analytic steps discussed above, which specifies the analytic framework that was deployed. Morrow (2005) avers the importance of balancing researcher interpretation with supporting quotations in presenting research findings. The analysis in Chapter Four is intended to accomplish this.

Researchers have also specified trustworthiness criteria for poststructuralist research (e.g., Madill et al., 2000; Morrow, 2005; Willig, 2013). Again, Morrow (2005) highlights *praxis*—the integration of theory and practice—and *authenticity*, which includes honouring participants' different constructions and elaborating them. This research's genealogy (Chapter Two), methodology and analysis (Chapter Four) are offered as evidence of its commitment to praxis. The below analysis also addresses authenticity through describing participants' various constructions of and subject positions toward dual diagnosis and dual diagnosis clients.

As discussed above, the interpretative nature of poststructuralist research means that any analysis is merely one reading of the data. Consequently, such inquiries are ultimately assessed on their own merits and the plausibility of their findings. These findings should cohere around assertions of the historical location of the research topic at hand, and enhance consciousness of issues of power therein (Madill et al., 2000; Ponteretto, 2005; Walker, 2015). I will appraise the trustworthiness of my own analysis in Chapter Five.

Finally, Morrow (2005), proposes a criterion of *transgressive validity* for poststructuralist research. Here, trustworthiness relates to the research's capacity to raise awareness of implicit power, incite discourse and contribute to a critical social science. Although this research's ambitions were modest in this regard, since I approached it from an explicitly ideological stance—and it is conceptualised within

the critical psychology tradition—this validity is applicable here. I will also critique this study in this regard in Chapter Five.

Chapter Four

Analysis

4.1 Introduction to Chapter Four

In this chapter I will present the findings of my analysis of interviews with ten participants about their experiences of working therapeutically with dual diagnosis clients. It is structured in the context of this project's research question: *"What are the power relations in practitioners' accounts of working therapeutically with dual diagnosis clients?"*. As discussed above (see section 3.3.4), this analysis was informed by Willig's (2013) FDA model. Parker (1992, 2013), Hook (2007) and Arribas-Ayllon and Walkerdine (2008) have also developed broad FDA strategies, which I considered and found useful.

In addressing my research question, I will first detail the circulating contemporary discourses—or *discursive regimes* (Foucault, 1980/1991)—identified in this analysis. These provided the context for the investigation of participants' therapeutic subject positions, of which I identified five. It should be noted, however, that I make no claims to this analysis' authoritativeness. As with any FDA, it represents one of many possible readings of the data. Moreover, I make no claim to material reality in analysing these discourses and their contingent power relations.

Table 1 shows the circulating expert discursive regimes, the subject positions that variously resourced these truth claims, and the illustrative discourses that accompanied these subjectivities.

Table 1

Summary of the circulating contemporary discourses, subject positions and their linked illustrative discourses

4.2 Circulating Contemporary Discourses of Dual Diagnosis	
4.2.1 A *medical-moral* discourse 4.2.2 A *recovery discourse* 4.2.3 A *war on drugs* discourse	
Therapeutic Subject Positions	**Illustrative Discourses**
4.3.1 The Adversarial Practitioner	*4.3.1.1 "Need for boundaries"* *4.3.1.2 "Danger of burnout"*
4.3.2 The Deskilled Practitioner	*4.3.2.1 "Where do I start?"* *4.3.2.2 "Insufficient training"*
4.3.3 The Advocate	*4.3.3.1 "Unwinding stigma"* *4.3.3.2 "Critiquing medicine"* *4.3.3.3 "Representing the client"*
4.3.4 The Expert	*4.3.4.1 "Wounded children"* *4.3.4.2 "Abject beings"* *4.3.4.3 "Learning on the job"*
4.3.5 The Critical Practitioner	*4.3.5.1 "Limited understanding"* *4.3.5.2 "Working differently"*

4.2 Introduction to the Circulating Contemporary Discourses

In talking about their therapeutic practice, these ten participants resourced three circulating contemporary discourses: a *medical-moral* discourse; a *recovery* discourse; and a *war on drugs* discourse. These competing regimes of truth seemed to objectify dual diagnosis clients in diverse and sometimes contradictory ways.

4.2.1 A *medical-moral* discourse.

Medical constructions of dual diagnosis are, I have argued in Chapter Two, infused with moral judgements. Here, clients' issues are constituted as "a maladaptive personal choice" (Broadus & Evans, 2015, p. 116) resulting from a deficit of self-control or will power.

Excerpt 1

So yeah there's more of this flying off and disappearing. Which is frustrating for a therapist, although it's what we work with and we have to understand it happens, and in addiction it does happen. But it seems to happen more with dual diagnosis, they are less reliable. (Eli, 719-723)

Excerpt 2

INTERVIEWER: What in your work with dual diagnosis clients have you found most difficult or frustrating?

FAY: Their unwillingness to change. (Fay, 459-461)

Excerpt 3

…as a clinician you're going to fix me. And if you don't fix me, I'm not gonna engage with you. And if I don't engage with you, I'm gonna try to make you feel that you're responsible for me. (Lawrence, 482-485)

In these excerpts, Eli and Fay objectify their clients as "less reliable" and "unwilling to change". Lawrence asserts that they will attempt to make him feel "responsible", which, by inference, seems to produce clients as unwilling to take responsibility for themselves. These accounts appear to mimic dual diagnosis clients' constitution in the psychiatric literature as lacking motivation and being difficult to treat or engage (see section 1.2). Within this discursive regime, then, dual diagnosis clients are constructed as irresponsible, perhaps even feckless. Their ascribed shortcomings of character may also complicate clinical practice. This seems to repeat early medical discourses of madness and addiction (see sections 2.2, 2.3.2). It could therefore be argued that contemporary medical-moral discourse is a similar example of objectification by dividing practices (Foucault, 1983/2002).

4.2.2 A *recovery* discourse.

This discourse seems to contrast markedly with medical-moral truth claims: as discussed above (see section 2.3.8), the recovery movement developed in opposition to medical practice. A key feature of recovery-focused treatment is a commitment to addressing the impact of stigma on clients.

Excerpt 4

The majority of the clients who would come to us, essentially were perceived as the lowest of the low (Dora, 786-787)

Excerpt 5

So it's, err, very very very easy for dual diagnosis clients to slip through the cracks. Because they are seen as difficult to work with and, a lot of clinicians don't want to work with them, in my opinion. (Lawrence, 723-726)

Excerpt 6

I think that comes in as, "there's something wrong with that person". And I think that's introjected by the client. And, if we're not careful, by, by agencies as well. I think we have to be very clear about that. (Tony, 503-507)

These participants note the impact of stigma on dual diagnosis clients, here. For Dora, they are "perceived as the lowest of the low", while Lawrence claims they are considered "difficult to work with" by clinicians. Tony talks of judgements that "there's something wrong" with clients. These judgements can be "introjected by the client" and "agencies as well", and can also "make it easy for clients slip through the cracks". Recovery discourse therefore objectifies clients as subject to—and perhaps victimised by—stigma, including by medical or psychological practitioners. It thus seems not merely a counterpoint to medical-moral discourse, but antagonistic towards its dividing practices.

4.2.3 A *war on drugs* discourse.

As noted above (see section 2.3.6.3), war on drugs discourse objectifies drugs and drug users as an existential yet nebulous threat. It categorises them in reductive binaries of health and illness and life and death, and can induce panic and a need for action. Perlman and Jordan (2017) have noted its impact on drug services in the deployment of militaristic metaphors, such as *targeting*, *capturing*, t*racking* and *surveillance* in relation to clients and treatment.

Excerpt 7

…and how things are now, we're in a timebomb for [*sic*] terms of dual diagnosis. (Jane, 938-939)

Excerpt 8

…I guess it is a bit of a battlefield, and you're kind of - my experience, especially as a trainee, was that you were being shot at by all sides. (Dora, 1029-1031)

Excerpt 9

…it depends really on what they're using, the consistency of it, umm, and sadly if it is substances there's only one place you're going, and that's six foot under. (Susan 590-593)

These excerpts seem to encapsulate this panic and need for action. In casting dual diagnosis as a "timebomb", Jane conveys its potential gravity and deadliness. Dora locates her practice on a "battlefield", where her safety is at stake. And Susan objectifies "substances" as inevitably lethal, irrespective of type; thereby demonstrating this discourse's reductiveness. War on drugs discourse therefore seems to construct dual diagnosis practice as a perilous undertaking, both for practitioners who may be "shot at", and clients who may end up "six foot under". It appears to objectify clients as dangerous, or alternatively in danger, because of their drug use. Clients are inconsistently defined, within this discursive regime.

4.3 Introduction to the Therapeutic Subject Positions

For the purposes of this analysis, the above circulating contemporary discourses provided different frames of intelligibility for participants' accounts of dual diagnosis work. I identified five therapeutic subject positions, which were resourced by these discourses: the Adversarial Practitioner; the Deskilled Practitioner; the Advocate; the Expert; and the Critical Practitioner. These located practitioners within distinct sets of power relations.

4.3.1 The Adversarial Practitioner.

Two participants, Lawrence and Dora—a CoP—mobilised this subject position most prominently in their accounts. They resourced both medical-moral and war on drugs truth claims in doing so.

4.3.1.1 "Need for boundaries".

Excerpt 10

No I would, I would, err, be of the opinion that boundaries are absolutely primary in dual diagnosis patients. (Lawrence, 109-110)

Excerpt 11

Umm, and pushing back with your own boundaries. "No, you can't arrive 50 minutes late and expect to be seen, I'll see you next week". And that's constant, that to and fro. (Dora, 1021-1023)

As argued above, in medical-moral discourse dual diagnosis clients are seemingly objectified as feckless or irresponsible. Mobilising a subjectivity resourced by this discursive regime—and its attendant dividing practices—seems to engender an adversarial relationship between therapist and client, in which "boundaries are absolutely primary". Through their assertion of the fundamental importance of maintaining these boundaries in their practice, Lawrence and Dora implicitly construct clients as constantly trying to test these boundaries. This seems to position these clients as disobedient and in need of discipline. Indeed, Dora asserts the importance of resisting this pressure by "pushing back". Thus practice seems to be objectified as a constant battle for control in which practitioners must actively assert their authority, which effectuates dominating top-down power relations. This subject position seems to locate practitioners and clients within a rigid moral order, with

practitioners assuming an authoritarian parental position in relation to their childlike clients. It seems to repeat doctor-patient power relations in early psychiatric treatments of mental illness and addiction (see sections 2.2, 2.3.2).

4.3.1.2 "Danger of burnout".

Within the Adversarial Practitioner subject position, then, therapy seems to be constituted as a power game in which practitioners must defend their own position.

Excerpt 12

I think it's very easy to burn out working with dual diagnosis clients. I could think that people could maybe have a four to five-year frontline life in that kind of work because I think it is hugely challenging, and hugely exhausting work as well, psychologically. And with very few rewards. You get the golden nuggets, but they're very few and far between. (Lawrence, 689-695)

Excerpt 13

And it is - it's one of those services where I feel like burnout could be a real thing after ten years working there. I think it's a field where, without supervision and without support from a colleague you would have to walk away. Because it's lonely. (Dora, 1040-1044)

Excerpt 14

… I think if you don't have [support] in place, then you leave yourself very exposed to the kind of chaos that is gonna exist there. (Lawrence, 170-176)

Within this subject position, the threat of burnout in practice clearly looms and the rewards—or "golden nuggets"—are rare indeed. Lawrence also deploys militaristic metaphors to construct his experiences of dual diagnosis work, which occurs on the

"frontline", much as Dora locates her practice on a "battlefield" (Excerpt 8). In conjunction with their depiction of their work as "hugely exhausting", "lonely" and with the potential to "leave yourself very exposed", this military language renders this practice not merely grim, but dangerous.

By resourcing war on drugs discourse, these participants seem to objectify clients as *antagonistic drug Others* (see section 2.3.6.3), who may cause burnout or "chaos". In this context, then, the Adversarial Practitioner subject position objectifies clients not merely as difficult or disobedient but as the malignant source of formidable problems in the work. Participants who mobilise this subject position are seemingly preoccupied with protecting themselves from their clients: there appears to be scant concern for clients' welfare, here. Thus, I argue, the subject position could be seen to abrogate any responsibility towards dual diagnosis clients.

The Adversarial Practitioner subject position is therefore inauspicious for the prospect of therapy. By constructing clients as difficult or even dangerous, this subject position seems to foster a need for action. But this action is defensive, and centred on preserving practitioners' authority or safety. The Adversarial subjectivity therefore seems to enact or perpetuate dominant power relations over clients, which may further legitimise their stigmatisation or exclusion from services. Participants who mobilise this subject position seem to uncritically adhere to medical-moral or war on drugs discourse. It seems to represent a "submission of subjectivity" (Foucault, 1983/2002, p. 322) to these regimes of truth.

4.3.2 The Deskilled practitioner.

Several participants, including Dora most notably, mobilised a Deskilled subject position in their accounts of working with dual diagnosis clients.

4.3.2.1 "Where do I start?".

As discussed above (see section 2.4) there has been a discursive bifurcation of mental illness and addiction within medical expert knowledge over the past forty years. This delineation may therefore be considered a feature of medical-moral discourse, which resources this knowledge system.

Excerpt 15

I think most things, when you have more than one diagnosis, there [*sic*] always that kind of chaos of what you do first, and who deals with it, and always a differing of opinion. Umm and that's gonna rise in chaos. (Dora, 206-209)

Excerpt 16

You've got so many of these, err, just significant mental health diagnosises [*sic*]. Yes, you can go with the addiction approach because that's all quite, been you know, kind of researched. But then where are you going to aim your mental health approach? (Lawrence, 750-754)

Excerpt 17

…with dual diagnosis it's what am I dealing with here, am I working with this, or am I working with that? And I've worked with that and I'm getting an improvement. But the more I improve and dig them out of that, the more they often go down on the other side. So it's almost like scales. (Fay, 461-466)

In these excerpts, participants appear to draw on this medical-moral truth claim, with Dora's talk of "more than one diagnosis", Lawrence's contrasting of an "addiction approach" with a "mental approach", and Fay's questioning whether she is "working with this, or…working with that". This seems to lead these participants to objectify their clients as highly complex, and clinical practice as confusing or perhaps even

frustrating: the more Fay "digs [clients] out of" one area, "the more they often go down the other side". For Dora, this confusion seemingly takes on a more pernicious quality, leading "always [to] a differing of opinion" and a "rise in chaos". In resourcing medical-moral discourse, these participants therefore seem to mobilise a Deskilled Practitioner subject position. The confusion and uncertainty that accompanies this position appears to leave them unsure what to focus on or where to begin, in their practice. Lawrence and Dora also seem to accept diagnostic categories unquestioningly in these accounts. This apparent reification may enhance their Deskilled subjectivity, by reinforcing the construction of dual diagnosis clients as having "so many of these…significant mental health diagnosises".

4.3.2.2 "Insufficient training".

Several participants spoke about their training in a manner that also mobilised the Deskilled Practitioner subject position.

Excerpt 18

INTERVIEWER: Umm, so how did your training […] help to prepare you for work with this client group, would you say?

TONY: Hmm (.) well, I don't think it does. I don't think it does. I think it maybe highlights what my limitations are, or with the training, with regards to working with a particular client group. And at best maybe to make an assessment as to whether that was inside my capacity, or whether I need to refer, you know, a person to, err, yeah to another, some other psychological services. (Tony, 24-34)

Excerpt 19

DORA: And especially then when you add in potential like gender confusion, or maybe bullying and stigma from different gender identities into then anxiety, depression *and* drug and alcohol…

INTERVIEWER: Yeah

DORA: It's like a minefield of what you're touching. And I feel there isn't the preparation for that. (Dora, 318-322)

In the above excerpts, Tony positions his training as effective only insofar as it "highlights" his "limitations…with regards to working with a particular client group". Dora similarly depicts hers as not providing "the preparation" for dual diagnosis practice, which she locates in a "minefield". This seems to amplify the potential consequences of this lack of training, for her. In their accounts, then, these participants seemingly construct training as inadequate in preparing them for the challenges of working with dual diagnosis practice. This, I argue, locates them in the Deskilled Practitioner subject position, within which they seem to question their own capacity to work with this client group. Moreover, this subject position may abrogate the responsibility to undertake this work: in objectifying his training as failing to provide the necessary resources to work with dual diagnosis clients, Tony may justify referring dual diagnosis clients to "some other psychological services". This subject position may therefore effectively perpetuate problematic practitioner-client power relations.

The Deskilled Practitioner subject position also seems to offer little promise for the prospects of clinical practice. In objectifying clients as highly—or threateningly—complicated, and training as failing to prepare them for this complexity, these participants again seem to experience a negative subjectivity about their work. Unlike the Adversarial subject position, however, here this negativity seems to leave participants with limited agency. Moreover, the Deskilled Practitioner subject position can lead practitioners to justify excluding clients from services.

Excerpt 20

…what I would say is I'm being much more careful now and it is the dual diagnosis that has brought that about. Because the dual diagnosis – they simply – we are, we're here in a way, we're not goal-driven but if I had – we see about 130 clients a year I suppose for long term therapy. You know some of them stay for six months, some of them only for you know 12 weeks, some of them for two years. But about 120 people over a year come through these doors. And if we're taking 40 people with personality disorder and only five of those are showing any great improvement, then I'm afraid statistically it doesn't work. We don't work as a service. (Eli, 775-786)

Here Eli, who runs a substance misuse service, seems to resource medical-moral discourse in two ways. First, in an apparent reification of the diagnostic category of "personality disorder", and second in his connection of this category with a lack of "any great improvement in therapy", which echoes the construction of dual diagnosis clients as making especially slow progress in the psychiatric literature (see section 1.2). In unquestioningly resourcing these truth claims, he mobilises the Deskilled Practitioner Subject Position: practice with dual diagnosis clients has "made him much more careful now" and may ultimately mean "we don't work as a service". In short, he seems to constitute these clients as too complicated or unwell to treat. In this excerpt, then, the Deskilled subject position seems to engender or perpetuate dominating power relations. Moreover, these power effects appear especially troubling in this instance because they are unthinkingly activated in the context of an uncertain and non-agentic subjectivity.

The Deskilled Practitioner subject position, and its contingent power relations, seems to illustrate the difficulties that can accompany a sense of lack of competence in practice. This may be particularly relevant, perhaps as a cautionary example, to

CoPs who are expected to negotiate multiple expert knowledges in their own practice, in areas in which they may not be experienced (Jones, 2017).

4.3.3 The Advocate

This subject position was primarily resourced by recovery discourse, and its emphasis on destigmatisation. While most participants mobilised this subjectivity periodically in their accounts, Jane, Susan and Kathy did so most prominently.

4.3.3.1 "Unwinding stigma".

Excerpt 21

You know I'll say things like, "look let's just kick this stigma out the window, shall we? Let's like, you know, let's have this open conversation here". (Jane, 804-806)

Excerpt 22

How we all are with people, we're very (coughs) sorry - very supportive, very non-judgmental and we can talk about anything. And actually that, that, it really settles people really quickly (Susan, 1080-1082)

Excerpt 23

…I think part of the therapy at the start of the therapy, when you're building a relationship, is making sure that you are not a - stigmatising the person, you are not labelling or judging the person. Therefore it's almost making them understand why their unhappiness, uh, using, and anybody might have gone through the same situation, might have end up in the same (.) going through the same experience might end up in the same situation as them. (Kathy, 494-501)

Excerpt 24

…part of recovery is about umm (.) forgiving oneself and actually understanding oneself. So you're not actually full of shame and full of guilt, and actually living up to those kind of like, stigmas. (Susan, 1102-1105)

In these accounts, participants construct their practice in terms of destigmatisation. Jane "kicks this stigma out the window", and Susan is "very non-judgmental". Kathy cites the importance of "not labelling or judging the person" at the start of therapy. This seems to position them as empathic practitioners who are attuned to their clients. They can have an "open conversation" and "talk about anything", which "settles people really quickly".

As I have argued above (see section 4.2.2), recovery discourse seems to objectify dual diagnosis clients as victims of stigmatisation. Susan appears to do so here in describing recovery as no longer "living up to…stigmas". Working up clients as victims may lead to practice becoming directive or didactic. For Kathy, therapy involves "making [clients] understand…that anybody might end up in the same position as them", and Susan constitutes recovery as "actually understanding oneself", which implies that prior to recovering these clients lacked this self-understanding. These participants thus seem to construct their clients as passive and unsophisticated in comparison to their capable and understanding selves, here. This engenders unequal practitioner-client power relations.

4.3.3.2 "Critiquing medicine".

Participants are also sharply critical of medical practitioners and services, in this subject position.

Excerpt 25

…a lot of the medicalised model doesn't get near to, you know, what's happened to you? (Jane, 518-519)

Excerpt 26

Umm a lot of the, a lot of the difficulties with dual diagnosis work is GPs don't have a, a good - so you might get a GP that's good with an understanding of mental health, but absolutely no idea about substance misuse. (Jane, 925-928)

Excerpt 27

I think when I worked in drugs and alcohol, the main issue was around getting people into mental health services, trying to get them to take the client seriously. That they had, umm, you know that they had issues worth referring them for… (Adele, 286-289)

In these excerpts, Jane constructs the "medicalised model" of dual diagnosis as inadequate. Additionally, or perhaps because of this shortcoming, she constitutes GPs as failing to understand it. This lack of understanding is then the source of "a lot of the difficulties with dual diagnosis work". Adele similarly appears to assert that mental health services are inclined not to "take the client seriously". This subjectivity seems to locate practitioners firmly in opposition to medical perspectives of dual diagnosis. Indeed, Jane seems to demonstrate that they may even be rejected outright. This dismissal is especially problematic from a counselling psychology perspective, which entails traversing multiple knowledges reflectively in practice. It also highlights how these participants appear to rigidly adhere to recovery truth claims in working up their practice.

4.3.3.3 "Representing the client".

This oppositional positioning leads participants to advocate on clients' behalf in interactions with medical or mental health services.

Excerpt 28

Umm, so you know, with what's frustrating and difficult is when, like for example with my client that I took to the early intervention team, and they said, "he's not got a primary psychotic illness". It's like well, umm, well maybe not but he is having these symptoms and he is having trouble with his mental health. And I really really pushed for that. And like, I actually got quite frustrated in one of the meetings. And I had to stay very contained 'cause I was like, I was so angry. (Jane, 694-701)

Excerpt 29

So then part of the job as a, I think as a therapist in a, in a, in a substance misuse service is to deal with mental health services. And try to see if you can, err, make a referral, or create a link or with, with substance, with mental health services and see if we can do some joint working together. (Kathy, 264-269)

Excerpt 30

You have to be prepared as well I think, to advocate on behalf of this client group (Adele, 259-260)

Jane, Kathy and Adele seem to fashion this advocacy as a matter of course in their practice, here. And, for Jane, this may necessitate conflict with medical services and staff. Therefore, in contrast with the Deskilled subjectivity, participants here seemingly position themselves as competent and capable practitioners *and* representatives for their clients. Indeed, they fashion themselves as caring for their

clients both within and beyond the consulting room. They seem to take on a hyper-responsible position towards their victimised clients, who are simultaneously rendered impotent and enfeebled, and requiring this advocacy.

In this way, this subject position also represents a near-diametric inversion of the Adversarial subjectivity: here participants represent clients in the face of other practitioners' oppression, rather than defending themselves from clients who are a threat. I argue, then, that the Advocate is a resistant subjectivity. Yet this resistance is worked up in terms of the dominant medical approach it intends to repel: as Jane exemplifies (Excerpt 25, 26), it involves a negation of this medical perspective. This seems an example of tactical reversal (Foucault, 1976/1998; see section 1.5), where resistance confronts a dominant force—here the medical approach—directly. However, this resistance will be futile because it is limited to either complying with or refusing the dominant force's challenge. Therefore, the resistance in this subject position is bound to be ineffective.

Moreover, by constituting clients as victims, this subject position appears to disempower these clients in relation to practitioners. The forces of abjection by which subjects are formed and circumscribed (see section 2.4.1) are present in this subject position, as Excerpt 24 may illustrate: Susan objectifies her clients as "full of shame and…guilt", and "living up to…stigmas". Consequently, the Advocate subject position may merely substitute clients' subjugation through a medical dominance for their oppression through the discursive regime of recovery. This is antithetical to the recovery movement itself, which, as noted above (see section 2.3.8), aims to reorganise power arrangements between practioners and clients. At minimum, participants deploying this subject position seem to mobilise a language of empowerment without changing service users' experiences within this practice (Masterson & Owen, 2006). Similarly, in rendering clients abject this subject

position, which ostensibly affirms these clients' legitimate place in society, may paradoxically locate them as non-subjects.

The Advocate subject position, then, seems inadvertently to perpetuate the power relations that it aims to combat. It highlights the dangers of practitioners being unaware of the discursive power games within which they—and their practice—are located (O'Callaghan, in press). This subjectivity calls to mind Room's (2005) observation that "the literature on stigmatisation seems generally to be less alive to the possibility that efforts to reduce stigma may also have unintended effects" (p. 150).

4.3.4 The Expert.

Participants also widely used this subject position, in their accounts. Unlike the Advocate subjectivity it was resourced by several different discursive regimes, which participants drew on in different ways.

4.3.4.1 "Wounded children".

Excerpt 31

Because for me, addiction comes from a very early narcissistic wound. Yup, very early. (Fay, 170-171)

Excerpt 32

…and then there are all the drives that are kind of behind the addiction. Or, you know err, past wounding, trauma, shame-based identities, that kind of thing. (Tony, 83-85)

Excerpt 33

In these excerpts, participants seem to construct clients' problems in terms of developmental wounding. These traumatic early life experiences may give rise to "addiction" for Fay and Tony, or "mental health issues" for Jane. This construction seems to resource psychoanalytic and psychological addiction discourse (see sections 2.3.6.1, 2.3.6.4, 2.3.7.1). Through their apparent valorisation of this discourse, these participants seem to affirm their own comprehension about the roots of dual diagnosis, and so position themselves as Experts in the field. Fay, for example, confidently states where "addiction comes from", and Tony lists "all the drives…behind the addiction".

I have argued above (see sections 2.3.6.1, 2.3.6.4, 2.3.7.1) that these psychoanalytic and psychological truth claims objectify clients as childlike in their incapacity to manage their own experiences, and so repeat the power dynamics of psychiatric discourse. It seems that these participants' accounts similarly produce childlike clients, here. Although they may be constructed here as more vulnerable, rather than impulsive and disobedient as in the Adversarial Practitioner subject position, this Expert subjectivity seems to engender similarly unequal power relations. In locating themselves as Experts, these participants position themselves as benevolent and perceptive adults in relation to their clients.

In mobilising an Expert subjectivity, these participants also seem to resource medical-moral truth claims by differentiating addiction and mental health problems. This can have significant implications for practice.

Excerpt 34

…I-I guess it became, the drug and alcohol became a function. So we'd see the other part of the dual diagnosis, as in the mental health condition, as the primary diagnosis, regardless of whether the addiction was more apparent. (Dora, 298-302)

Excerpt 35

…I enjoyed it because you then, as a psychologist, you have a luxury in a way to work with a, with a mental health problem with having - and you can almost at times ignore the alcohol or the drug abuse, and concentrate on the person. (Kathy, 88-92)

Here, these participants—both psychologists—seem to draw on this differentiation to discount clients' substance use in their practice. Dora asserts that mental health problems are "the primary diagnosis", much as Jane (Excerpt 33) seems to claim that you "throw substances on top" of mental health problems in dual diagnosis. Kathy's comment that ignoring substance use allows her to "concentrate on the person" seems to reinforce this construction of substance use as extraneous. The discursive bifurcation of addiction and mental illness, therefore, seems to afford them an Expert subjectivity, in their practice. They position themselves as knowing what to address, and what to ignore. This seemingly renders their clients less complex, which may entrench this Expert subject position.

These accounts therefore seem to illustrate the power of the psy-complex (see section 2.2), which allows practitioners to gain authority over their clients by bringing order to disorder through the application of regimes of truth (Foucault, 2000a). While this may make dual diagnosis practice more intelligible, it does so here at the cost of disregarding a significant component of these clients' experiences. Therefore I argue that the Expert subject position, in these excerpts, may be seen as reductive and inflexible.

4.3.4.2 "Abject beings".

Several participants mobilised an Expert subjectivity by emphasising dual diagnosis clients' abjection.

Excerpt 36

…somebody with dual diagnosis is much more likely to be either drinking on their own, or with a very dysfunctional group of drinkers, like hanging around outside a YMCA or whatever in […] than, than in the pub with some high achievers who like drinking (Eli, 640-644)

Excerpt 37

My experience of dual diagnosis was, that tangible link was only their drug dealer. Or the l-off licence that was selling them alcohol. They had no other social circles, especially not prosocial. They didn't have any at all. (Dora, 844-848)

Here, these participants seem to objectify clients as socially inadequate: Eli contrasts their "dysfunctional" drinking with that of "high achievers", and Dora works them up as having no "prosocial" circles. This seems to epitomise the forces of exclusion and abjection that form and delimit the liberal subject (Butler, 1993; see section 2.4.1). In constructing dual diagnosis clients as abject, these participants seem to marginalise clients and perhaps locate them exterior to this liberal subjectivity. Interestingly, Dora then appears to offer clients a pathway back to the domain of the liberal subject through her status as a CoP.

Excerpt 38

And that's where I think, the holistic nature I guess of counselling psychologists, the way they look at individuals, comes into it because you'd be more better

prepared necessarily for the bigger picture to prepare them for social life and society. (Dora, 864-868)

Dora, I argue, resources recovery discourse here by valorising the normative construction of this recovery as *a return to the rights, roles and responsibilities of society* (see section 2.3.8). Doing so seems to locate her as an Expert who can facilitate this process. Moreover, she seemingly claims this power specifically for CoPs, thereby perhaps privileging them as first among Experts. This also seems to fix clients within a dominating moral order, once more: as abject beings they are inferior to and perhaps reliant upon sober and responsible Expert practitioners. Dora's assertion also seems to exemplify Rose's (1998) argument that the source of psychology's position of power is its capacity to offer a "promise of personhood" (p. 88), through its governmental practices.

The construction of clients as wounded children or abject beings in participants' accounts has further implications for practice.

Excerpt 39

Oh there's always a sense that, you know, progress will be slow. And also, do I open up a wound that they can't sufficiently close in the session to go out in the real world. Cause this is a false world. So I have to judge how they are, and if I'm gonna go there will I give them enough time to recover so they can go back there. So it's like stripping them bare of their defences, that's how I see it. (Fay, 512-517)

Excerpt 40

Umm, and we're able to kind of use either directive or non-directive skills, or you know they don't always know that we're doing that, you know, when we encourage someone to speak up in group. Or, you know, they're not, it's not like we make them aware of what's happening. Sometimes it's just unconscious stuff that you know, we know what we're doing but the th - we don't, we don't like let them know exactly what's going on. 'Cause they wouldn't get it anyway. They'd be like, "what?" (*laughs*). (Susan, 727-735)

Excerpt 41

…I don't think there's enough counsellors and psychotherapists working in substance misuse, to really fully understand dual diagnosis and what, what's really going on with the client. (Susan, 1307-1310)

Here, Fay seemingly draws on psychoanalytic or psychological truth claims to objectify dual diagnosis practice as inevitably drawn-out, in part because of the need to "open up" or "sufficiently close" her clients' wounds. She then appears to construct therapy as a process of disassembling these damaged clients into their constituent parts, by likening it to "stripping them bare of their defences". In so doing she may implicitly affirm her own Expert position, by endowing herself with the power to reassemble or leave clients broken.

Susan constructs clients who "don't always know" what she is doing in practice, thereby seeming to render them unsophisticated or obtuse. She simultaneously appears to position herself as an Expert, who can use "directive or no-directive skills". This contrast may then justify not letting clients know "exactly what's going on. 'Cause they wouldn't get it anyway". She may buttress her Expert subjectivity through her claim that only "counsellors and psychotherapists" can "really fully understand dual diagnosis": this seems a self-legitimating assertion.

Again, in these excerpts the Expert subject position seems to generate a dominant power relationship over dual diagnosis clients. Within this subject position dual diagnosis practice is objectified as a prescriptive and normative process, which entails leading clients towards a preordained solution. Therapeutic work seems to function as a *regime of governmental practice* (Thompson, 2003), in these accounts. From a counselling psychology perspective, this is highly problematic because it is directive and may engender dominating power relations.

4.3.4.3 *"Learning on the job".*

Most participants mobilised discourses of experiential learning in relation to dual diagnosis practice.

Excerpt 42

…part of it was great 'cause it's learning on the job and I think that's almost what teaches you to be a psychologist, because it doesn't matter what you're taught in a classroom… (Dora, 264-267)

Excerpt 43

…although I was doing [counselling psychology] training, none of the training that I was doing was had anything to do with alcohol. I just had a very good…I started out working in a voluntary sector organisation for alcohol. They had an exceptionally good training programme with it. Very good supervision. It was very nicely structured. (Maria, 58-62)

Excerpt 44

Umm I don't think there was dual diagnosis training. I think the mental health training I run now is very focused on dual diagnosis. It really goes into it and explains it and - but when I came in, I wasn't, I wasn't really trained as such. I was lucky I was working with [_] and she gave me a lot of insight and kind of…
INTERVIEWER: So that was sort of your training, when you were sort of…
JANE: I think so, it was on the ground. (Jane, 242-246)

In these excerpts, participants seem to objectify their formal training as failing to prepare them for dual diagnosis practice, as did participants who mobilised the Deskilled Practitioner subject position (see Excerpts 18, 19). For example, Maria—a CoP—claims that her training did not have "anything to do with alcohol", and Jane says she "wasn't really trained as such". Unlike in the Deskilled subjectivity, however, they contrast this paucity with their experiential learning. This, for Dora, is "what almost teaches you to be a psychologist": she also appears to dismiss her formal training with her comment that "it doesn't really matter what you're taught in a classroom". By inference, these participants seem to constitute this experiential learning as enabling them to work with dual diagnosis clients. In Jane's case, it may even have helped her develop a training that *is* "very focused on dual diagnosis".

These participants therefore seem to privilege this "on the job" experience. In so doing, it could be argued that they effectively exclude those without this experience from the arena of dual diagnosis practice. These apparently self-legitimating accounts, then, position these participants as Experts in the field. But in laying claim to dual diagnosis practice as their exclusive preserve, they also beg the question whether this is in their clients' best interest (Jones, 2017).

4.3.5 The Critical Practitioner.

The Critical Practitioner subject position was the least frequently used subject position in participants' accounts. It was identified by a self-questioning reflexivity in the working up of dual diagnosis practice.

4.3.5.1 "Limited understanding".

Excerpt 45

MARIA: I think some of that still needs to emerge, actually. My feeling is that we're still in the early days of understanding what dual diagnosis might mean.

INTERVIEWER: Ok

MARIA: Right so there's probably a lot of work that needs to be done in order that things do emerge that we begin to understand in a better way. (Maria, 241-247)

Excerpt 46

…but I think what's taken to mean dual diagnosis generally, are people who, umm (.) what can I say that it's a different, because I'm not so certain of my own perceptions about this are […] present in a way that's a little outside of what maybe culturally is identified as the norms of behaviour and interaction. (Tony, 86-91)

Maria and Tony seemingly explore the current limits of dual diagnosis expert knowledges, in these excerpts. Maria appears to critique these knowledges through her claim that "a lot of work…needs to be done" to allow practitioners to "understand [it] in a better way". Tony seems to highlight the normative function of dual diagnosis, and perhaps objectify it as a social construct with his reference to cultural "norms of behaviour and interaction". By inference, he may therefore call into question its reality as a diagnostic category and demonstrate awareness of its contingent power effects.

Thus, it could be argued, these participants position themselves as agnostic towards dual diagnosis discourses. In an apparent contrast with the above subject positions, within this Critical subjectivity these systems of knowledge are not reified but produced as mutable and open to question, without needing to be dismissed.

Tony additionally deploys the Critical Practitioner subject position in discussing dual diagnosis clients.

Excerpt 47

You know, sort of completely different presentation, a different aspect of that person becomes more dominant. And it's like we're working with some, someone completely different. Yeah. Umm, but so I, I guess that's what I would find - I find myself trying to defend against, against the kind of labelling. And, yet - yet I'm kind of lost in terms of language (*laughs*). (Tony, 132-137)

Here, Tony's attempt to avoid "labelling"—or maybe drawing on contemporary discourses— seemingly leaves him "lost in terms of language". Butler (2001) has argued that the practice of critique "emerges, with the awareness that no discourse is adequate here, or that our reigning discourses have produced an impasse" (p. 3). It could be argued that Tony has arrived at this point: he seemingly lacks the discursive resources to adequately describe his work, and finds himself at this impasse. His talk, therefore, may illustrate the apparent paucity of contemporary dual diagnosis discourses.

In mobilising this Critical subjectivity, he may objectify dual diagnosis clients as unknowable others here: he can only describe them as "completely different". This may serve to distance him from his clients. However, the power effects of this positioning seem somewhat limited, compared with the above subjectivities. Describing clients as "different" does not appear to produce them as inferior, antagonistic or impossibly complex.

Maria also seems to mobilise the Critical Practitioner subject position while discussing her clients.

Excerpt 48

...if people were becoming a bit wobbly and they might not be taking their medication, and they then start using drugs that they of, that they're buying, then umm I think we just need to understand that sometimes those drugs that they're buying might be doing them better than the drugs that they were taking. So people that have a dual diagnosis sometimes might know a bit more about stuff that they're taking sometimes, than the people that are prescribing stuff to them do. (Maria, 249-256)

In questioning the limits of medical knowledge about drugs—and the expertise of those prescribing them—Maria appears to objectify clients, who "sometimes might know a bit more about stuff that they're taking", as complex and self-directed, and capable of making their own decisions regarding their care: she does not produce passive clients who need practitioners to represent them, in contrast with the Advocate subject position. This simultaneously seems to locate her as a self-questioning practitioner who is open to other perspectives.

I argue that Maria appears to draw on recovery discourse, here. She may demonstrate its requisite shift of expertise from practitioner to client (see section 2.3.8). Moreover, both she and Tony seem to interrogate constructions of addiction, drug use and mental illness, which recovery-focused treatment requires (Lancaster et al., 2015). Interestingly, these participants appear to avoid the normative constructions of recovery that may accompany this discourse (e.g., Excerpt 38). It seems they can resource it more flexibly, from the Critical Practitioner subject position.

4.3.5.2 "Working differently".

Within this subjectivity participants seem to display a non-defensive awareness of the limits of their knowledge. This in turn engenders a distinct approach to clinical practice.

Excerpt 49

…for me in my experience of working with someone that has a dual diagnosis is that I can't, how can I say I can't umm, fall back on what I imagine to be norm, normal or the norms in communicating with people. So I've got to be in this place of kind of real openness. Now, that might be (*laughs*) what a person working towards a good therapist wants to be. But I'm, I'm talking about something, err, more, more specific I think to that presentation, yeah. (Tony, 320-328)

Excerpt 50

I think there's a bit of room to sort of give a bit more say to [clients], really. (Maria, 749-753)

In stressing his non-reliance on the "norms in communicating with people" in his practice, it could be argued that Tony again critiques contemporary circulating dual diagnosis discourses. Instead, he asserts the importance of bringing an "openness" to his practice. While this may inferentially locate dual diagnosis clients beyond these "norms", thereby producing them as others once again, this does not seem to enact a dominating power relation over these clients. Maria's assertion that there is space in clinical practice to "give a bit more say" to clients also seems to construct them as able to speak for themselves. It thus positions them less as inferiors than her equals.

Interestingly these participants' apparent awareness of the limits of their knowledge does not seem to undermine their status as practitioners, in contrast with the Deskilled subject position, wherein uncertainty may be an impediment to practice (see Excerpt 16, 17). The Critical subjectivity is therefore argued to afford these

participants a sense of professional agency within limits: they neither locate themselves as omniscient, as may be true of the Expert subject position, nor as non-knowing. Moreover, they position their clients as complex and differently motivated, and capable of making their own decisions about their care. They seem to objectify practice not as a didactic, top-down process but a more egalitarian encounter, in which clients are as knowledgeable as practitioners. Therefore, I argue, this subject position appears to facilitate a more flexible approach to clinical practice and more balanced practitioner-client power relations.

The Critical Practitioner subject position, then, seems to engender a capacity for self-questioning and reflection on the limits and power effects of contemporary dual diagnosis discourses and practice. Within it, participants appear to avoid the submission of subjectivity that may characterise the above therapeutic subject positions. There, participants draw uncritically on discourses that become *laws of truth* (Foucault, 1983/2002) through which they rigidly constitute themselves, their clients and their practice. Perhaps, then, the Critical Practitioner subjectivity could be argued to be a technology of the self (see section 1.5). These participants' critique of dual diagnosis discourses seems to allow them to resist an imposed individuality, which affords some freedom in constituting practice, thereby facilitating more balanced power relations. This is more in keeping with counselling psychology's stance.

4.4 Summary of the Analysis

The analysis of these ten participants' accounts, I argue, demonstrates that dual diagnosis is a problematic discursive phenomenon, for counselling psychology. The application of a poststructuralist FDA showed that participants resourced several contemporary dual diagnosis discourses in their talk. These objectified dual diagnosis clients in ways that could be problematic for therapeutic practice, and sometimes

contradicted each other. Participants also deployed five therapeutic subject positions in their talk that engendered distinct sets of power relations. Four of these located participants in relations that lent themselves to the stigmatising and exclusionary practices that are prevalent with dual diagnosis. These again seemed inimical to clinical work. Only one subject position appeared to afford participants a critical reflexivity towards dual diagnosis, which arguably mitigated these power effects. This analysis therefore supports the argument that CoPs and practitioners more generally could benefit from attending to their talk about practice with dual diagnosis clients, to raise awareness of the truth and power games within which they may unknowingly be located. It may further provide a resource for practitioners to develop a reflexivity about this practice, which may facilitate less dominating power relations therein.

Chapter Five:

Discussion

> "My problem is to construct myself, and to invite others to share an experience of what we are, not only our past but also our present, an experience of our modernity in such a way that we might come out of it transformed. Which means that at the end of a book we would establish new relationships with the subject at issue" (Foucault, 1980/2000 p. 242)

5.1 Introduction to Chapter Five

In this chapter I will discuss and evaluate the present research's findings that were produced to answer the research question: *"What are the power relations in practitioners' accounts of working therapeutically with dual diagnosis clients?"*. I propose that this research contributes to the dual diagnosis literature and counselling psychology by raising awareness of the contingent power relations in psychological practitioners' talk about dual diagnosis, and how they may unknowingly be positioned—and locate their clients—within complex and dominating power relations in their accounts of therapeutic practice. As the analysis in Chapter Four highlights, dual diagnosis may be resourced by diverse and sometimes contradictory circulating discourses. This study therefore additionally illustrates how a poststructuralist, discursive perspective can shed new light on the acknowledged problems of dual diagnosis in contemporary UK health settings.

I will first evaluate the contribution of this research's findings to the broader diagnosis literature, and to counselling psychology. I will then evaluate the poststructuralist stance employed, and its application of a Foucauldian Analytic. Thirdly, I will offer a further reflexive commentary as a CoP researcher and practitioner interested in working with dual diagnosis clients. Finally, I will offer recommendations for future research. In discussing these findings, however, it is important to emphasise that they are one set of many possible from these ten participants' accounts. In keeping with this research's epistemology, I neither make essentialist claims to their material effects, nor any objective "truths" derived from

making visible some of the power games in practitioners' talk about working with dual diagnosis clients (Jones, 2017; Randol, 2014). I only comment on the truth claims within participants' talk, and seek to raise awareness through the rhetorical power of my arguments supported by the illustrative excerpts offered in Chapter Four (Willig, 2013).

5.2 The Research Findings and their Possible Contribution to the Dual Diagnosis Literature

In Chapter One of this thesis, I argued that a poststructuralist perspective is appropriate to investigate the asymmetric power relations between healthcare professionals and dual diagnosis clients identified in the literature (see section 1.2). I theorised that dual diagnosis seems a problematic discursive phenomenon, with concomitantly troubling power effects. In Chapter Two I presented a genealogy that argued that medicalised constructions of mental illness and addiction may share a discursive root as "*the psychological effect of a moral flaw*" (Foucault, 1964/2001, p. 148), in which discourses of willpower and agency feature prominently. This genealogy also problematised the bifurcation of medical discourses of mental illness and addiction that made a dual diagnosis possible. It suggested that this division has contributed to the problematic power relations between dual diagnosis practitioners and clients, and may have led to dual diagnosis becoming a discourse of exclusion in contemporary British health settings. Indeed, according to Foucault's extended version of discourse, which includes institutions and their practices (Potter & Hepburn, 2008), the structural segregation of mental health and substance use services and trainings may be considered less a discursive effect than a discourse itself. I proposed that dual diagnosis' referential ambiguity also contributes to the present difficulties of clinical practice, and may even engender the confusion and uncertainty that practioners can experience. A poststructuralist research method that

attends to the historically located constructive power of language may thus illuminate how dual diagnosis practice has assumed its present forms, in ways that a more realist epistemology conceptualising dual diagnosis as an objective, pre-existing phenomenon cannot.

The FDA in Chapter Four produced two aspects of interest, from a critical-ideological perspective (see section 1.6). First, it illustrated some of the various contemporary dual diagnosis discourses that this research's participants resourced in their practice. These were sometimes competing and contradictory, which seemed to contribute to rendering dual diagnosis practice complex and confusing. This research identified a recovery discourse (see section 4.2.2) that functioned as an explicit counterpoint to the medical-moral (see section 4.2.1) regime. However, the resistant power of the recovery discourse seemed limited by its repudiation of the medical-moral perspective. It seemed more to negate this medical expertise than offer an alternative construction of dual diagnosis. Therefore it seemed to exemplify the limited forms of resistance that Foucault's strategic power model allows (see section 1.5), wherein one can only affirm or reject the dominant discourse.

Another feature of these circulating expert discourses was their apparent paucity (see Excerpt 47). None seemed to encapsulate the experience of dual diagnosis practice such that participants could resource it exclusively, during an interview. Rather, participants resourced different discourses at different times, rendering their talk contradictory. This too may partly explain the confusion and uncertainty that marks dual diagnosis practice, at present. These circulating discourses also seemed to embody Butler's (2001) assertion that "the categories by which social life are ordered produce a certain incoherence or entire realms of unspeakability" (p. 3).

The FDA also identified five distinct power-related subject positions, which were resourced by the circulating expert discourses: this was its second main finding.

Each had implications for therapeutic practice with dual diagnosis clients. For example, the Adversarial (see section 4.3.1) and Deskilled Practitioner subjectivities (see section 4.3.2) seemed to entrench asymmetric power relations and perhaps stigmatisation and service-exclusion in practice. The Advocate subject position (see section 4.3.3) did so as well, although by separate means. Its perpetuation of dominating power relations within an ostensibly resistant subjectivity is especially interesting to this research: see below. The Expert subject position (see section 4.3.4) may have demonstrated the impact of the bifurcation of mental health and addiction discourses on dual diagnosis practitioners. It may have facilitated the reductive construction of dual diagnosis practice that several participants demonstrated (see Excerpt 34, 35), by privileging an expert mental health knowledge over that of addiction in their efforts make practice intelligible and manageable.

This research's participants deployed the Critical Practitioner subject position (see section 4.3.5) most rarely in their accounts. Participants' apparent difficulty in sustaining a critical and reflexive subjectivity regarding dual diagnosis and practice was thus notable. Perhaps it suggests that maintaining such a critical perspective with dual diagnosis clients is particularly difficult, or that dual diagnosis expert discourses may discourage such a subjectivity. However, this research's poststructuralist epistemology posits that these subject positions may be deployed by any practitioner, and each offers its own opportunities and constraints (Jones, 2017).

Several participants mobilised discourses of training deficiencies in their accounts, which resourced the Deskilled and Expert subjectivities (see sections 4.3.2.2, 4.3.4.3). These participants constructed their training as failing to prepare them for the demands of dual diagnosis practice.

While such discourses may be commonplace among psychological practitioners, in the context of clinical dual diagnosis practice I argue that they have notable implications. This apparent deficiency of training may be a function of the discursive

segregation of mental health and addiction: in Britain, separate trainings are offered for mental health and addiction psychological practitioners. Thus the current structure of practitioner training seems to militate against facilitating effective practice with dual diagnosis clients. This research therefore suggests that the organisation of training provision should be addressed, to meet the demands that the apparently growing dual diagnosis client group may represent.

5.3 The Research Findings and their Possible Contribution to Counselling Psychology

This research also offers a contribution to counselling psychology specifically. First, it addresses the dearth of counselling psychology research on dual diagnosis. This is relevant, in light of dual diagnosis' apparent prevalence and the expectation that CoPs should work in a variety of healthcare settings.

Second, this research offers a critical perspective on how psychological practitioners construct their work with dual diagnosis that may facilitate the development of a critical reflexivity in practice. Moreover, through the Critical Practitioner subject position this research may demonstrate how practitioners have brought such a reflexivity to their work. It therefore shows that attending to the power relations in language affords a critical lens through which one may investigate one's own talk and consider what the truth claims therein may enable or constrain. Perhaps the poststructuralist perspective that subjectivity is constantly positioned and repositioned through talk (Randol, 2014) may also facilitate the holding of multiple, sometimes contradictory truth claims that counselling psychology practice demands. This research may thus additionally illustrate the practical potential and relevance of FDA to counselling psychology.

As discussed above (section 1.3), counselling psychology is committed engaging with issues of power, and fostering anti-oppressive practice. These are

matters of ethics (Shillito-Clarke, 2010). For Foucault (1991a, 1984/1992, 2000b, 2000d) critique is central to self-formation as an ethical subject. Ethics entails coming to a new self-relationship—or *rapport á soi* (Foucault, 1991a)—with the discourses and truth games that shape ourselves and our worlds. I argue that this research's facilitation of a critical gaze towards dual diagnosis may in turn afford an opportunity to develop a more ethical practice with dual diagnosis clients. For example, the findings discussed above suggest that in the ostensibly resistant and destigmatising Advocate subject position, dominating power relationships were perpetuated rather than challenged. Perhaps this was because dual diagnosis clients were defined in terms of their victimisation by others, within this subject position. Benhabib (1992) has argued that this reduces "subjectivity to the terms of the dominant discourse and does not allow for the ways in which it may challenge that discourse" (p. 83). The disruption of dominant power relationships and the marginalisation of clients, by contrast, requires the interrogation of expert discourses and constructs such as addiction and drug abuse (Lancaster et al., 2015; Seear & Fraser, 2014). One can never be exterior to power relations. Yet through a critical attitude one may "play the games of power with as little domination as possible" (Foucault, 2000b, p. 289).

Therefore, I propose that this research may provide a resource for CoPs to develop their own critical attitudes towards dual diagnosis, and so establish therapeutic relationships that are less riven with damaging power relations. This critical attitude may offer CoPs opportunities to "work on the limits of (our) culture, inventing new subjectivities and self-techniques by critically reworking the present ones" (Vintges, 2012, p. 289). These new subjectivities are, I argue, needed in dual diagnosis practice, to address its current issues: as presently constituted, dual diagnosis seems to be a discursive maze.

5.4 An Evaluation of this Research

In this section I will evaluate the FDA research method deployed in this thesis, to answer its research question. As with any method, choosing to use FDA necessarily offers benefits and limitations, due to the constraints of its underlying epistemological framework. These shape the parameters of what can be made visible and what knowledge claims may be produced (Willig, 2013). I also critique this research's data collection methods, and its relevance to counselling psychology. Finally, I revisit researcher reflexivity, from the position of having produced one of many possible readings of these data.

5.4.1 A critique of Foucauldian discourse analysis.

FDA seeks to investigate the constructive and constraining power of talk in constituting social and psychological realities. This affords a critical investigation of the links between therapeutic practice and broader cultural and institutional knowledge systems and power relations (Avdi & Georgaca, 2007). Its role within psychology research has been debated and criticised, in four main ways.

First, Avdi and Georgaca (2007) note that FDA's relevance to clinical practice has been questioned, due to its macro-level focus. However, they assert that FDA research can demonstrate the connection between therapeutic interactions, subjectivity and wider social processes by highlighting both the normative assumptions reflecting wider sociocultural discourses that therapists bring to their work, and the constructive role of discourses in clients' articulations of their problems within therapy. It can thus illuminate both macro- and micro-levels of clinical practice, and enhance its usefulness while retaining its critical perspective. While this study sheds no light on therapeutic interactions between practitioners and dual diagnosis clients, it has investigated wider power relations through its genealogy and local ones in its analysis of participants' accounts of therapeutic work. It may

therefore offer a legitimate resource for practitioners to develop reflexivity in their clinical practice.

Second, debates within psychology continue about the relationship between discourse, materiality, and subjectivity (Willig, 2000, 2013). Hook (2007), for example, has argued that FDA in psychology has failed to attend to the materiality of discourses and the physicality of their power effects, which gives Foucault's analyses their potency. This in turn has led to an excessive focus on textuality that locates discourse as an effect rather than an instrument of power. However, I argue that this notion of materiality implies an extra-discursive reality that is ontologically discrepant with poststructuralism's extreme relativism: as discussed above (see section 3.2), this research has adopted such a relativist position. Moreover, this relativism posits that the body itself is an overdetermined site of power, a "surface inscribed with culturally and historically specific practices and subject to political and economic forces" (King, 2004, p. 30). This body does not exist beyond discourse, but is rather shaped by it. Consequently, material or physical effects are themselves discursive, which is both the instrument of power and its effect. A textual focus is therefore argued to be appropriate in this research.

FDA's epistemological stance has also been criticised for theorizing subjectivity on discourse alone. While this accounts for the fluidity of subjectivity and experience—which this research's participants demonstrated by shifting between a range subject positions in their accounts—critics have argued it is less able to explain people's apparent investment in certain subject positions, and thus subjectivity's stability and unity (Willig, 2000, 2013). Indeed, it is unclear why this study's participants seemed to occupy some subject positions more than others. Hollway and Jefferson (2000) have proposed a psychoanalytic framework to account for this stability of identity and investment in subjectivities. However, I think this approach, too, may be incongruent with FDA's epistemological relativism, by

intimating an extra-discursive realm. Davies and Harré (1999) have suggested that individual life histories and experiences, through which people have been located in subject positions or related to people in these positions, can account for the stability of experience (Willig, 2013). Yet this view seems incompatible with poststructuralism's discontinuous and decentred self. This incapacity to adequately account for the continuity of experience therefore seems a limitation of the method: like all research approaches, FDA provides a specific lens that is necessarily limiting.

In a third area of debate, FDA's epistemological stance has been criticised for "offering only a nihilistic understanding of the subject that claims resistance is possible yet fails to offer any understanding of how" (Hanna, 2014, p. 146). As noted above (section 3.2), FDA undeniably posits a weaker actor than other discourse analysis approaches. Yet charges of nihilism are, I think, misplaced. While Foucault effectively mapped out how we are produced and imprisoned by discursive power relations in his early and middle work, the final works of his oeuvre concern themselves with how we might find a degree of freedom within the power games of discourse. The role of critique is central, here (Thompson, 2003).

Finally, some contemporary theorists have proposed that FDA is theory-rich but data-thin (Dickerson, 2012). I argue, however, that through conducting interviews with ten practitioner-participants this study generated sufficient data to substantiate its arguments. Nonetheless, as Willig (2013) notes, it is for the reader and not the author to decide whether an analysis has enough rhetorical power.

5.4.2 An evaluation of this research's data collection methods.

This study recruited an opportunity sample of ten psychological practitioners who had at least six months' experience working therapeutically with dual diagnosis clients. Recruiting an opportunity sample poses several limitations. First, this study's findings represent only the psychological practitioners who agreed to take part. A

different sample would inevitably have produced different results. However, any talk can potentially offer an analytic contribution, from a poststructuralist perspective.

With research based on a small sample, homogeneity among participants is sought. Due to concerns about finding enough CoP participants, I pragmatically recruited psychological practitioners more generally. Indeed, my sample included only two CoPs. Therefore this research's sample has more heterogeneity than may be desirable. Moreover, this sample was varied in age—mid 20s to mid 70s—and experience, which varied from 18 months to four decades. Interestingly, however, no influence of experience was noted in the analytic findings: while one participant who mobilised the Critical Practitioner subjectivity, Maria, was among the most experienced participants in the sample the other, Tony, was among the least. The participant sample was also diverse in gender. Seven participants were female, and three male. Gender did not seem to influence findings, with male and female participants mobilising a variety of subject positions in multiple ways. Participants also used a variety of therapeutic approaches in the work with dual diagnosis clients, which may be another form of heterogeneity. Again, I found no evidence of influence regarding therapeutic approach on this research's findings. And since CoPs are trained in at least two therapeutic approaches and draw on a diverse knowledge in their practice, this heterogeneity may be less problematic in the present context.

Importantly, I do not argue here that differences in age, gender, experience and therapeutic approach were irrelevant, but that the focus of this study did not allow such differences to emerge. Following Willig's (2013) advice, no demographic information on participants has been included in this study because such information may become a means to construct identities and locate persons in social categories that impose realities.

As discussed in Chapter Three, participants were individually interviewed about their experiences with dual diagnosis clients in this research. While interviews

are frequently used in discursive research (see section 3.3), Potter and Hepburn (2005) are critical of relying on interview data in such research because "whatever the interviewer does and however minimal their contribution is, participants will—to a greater or lesser extent—*attend to that in their talk*" (Dickerson, 2012, p. 259, emphasis in original). Consequently, the interviewer may bias the process excessively. Moreover, they argue, this bias may be particularly problematic in one-to-one interviews, such as those used in this study (Potter & Hepburn, 2005). While poststructuralist research acknowledges that researchers will inevitably influence every aspect of the research process, they should also try to counteract this bias. (Harper, 2003; Finlay & Gough, 2003). The use of one-to-one interviews in this research may therefore be a limitation.

Steffen (2016) has raised ethical questions regarding the use of discourse analytic research methods. She notes that participants might not give consent if they "realised that the accounts they provided would not be used to gather information about a phenomenon but to obtain a sample of the discursive practices they employ" (p. 41). This is balanced against concerns that gaining informed consent for such research by making the method explicit might lead participants to become self-conscious, thereby undermining it. These concerns seem rooted in a realist ontology that separates phenomena from discursive practices. Moreover, any inductive research process necessarily involves uncertainty about the research method to be used, until data analysis is underway.

While the above limitations are acknowledged, the individual interviews also yielded rich data, for the purposes of the analysis. These afforded insight into three circulating and sometimes contradictory expert discursive regimes, which contextualised and circumscribed participants' accounts of their therapeutic practice. They additionally allowed the identification of five subject positions, which again were contradictory and inimical to good therapeutic practice, at times. Alongside the

genealogy's assertion that dual diagnosis currently functions as an exclusionary discourse in contemporary health settings (see section 2.4.1), the data therefore seemed to shed new light on some of the acknowledged difficulties of dual diagnosis practitioner-client relations in the expert literature (see section 1.2). This research identified dual diagnosis as a problematic discursive phenomenon, which may partly account for these difficulties. This in turn illustrates the capacity of FDA to investigate and illuminate problematic areas of practice in novel and unexpected ways.

5.4.3 An evaluation of this study's relevance to counselling psychology.

The limited number of CoP participants in this study impacts its relevance to counselling psychology. Had this research attained a more homogeneous sample, its relevance would certainly have increased. However, as CoPs resource and deploy a range of therapeutic modalities and knowledges in their practice, this limitation's effect may be mitigated. Furthermore, all therapeutic talk is broadly helpful to psychological practitioners, including CoPs.

As discussed above, Morrow (2005) has argued that qualitative counselling psychology research has general criteria of trustworthiness (see section 3.5). I will again address the criterion of social validity through further comments on researcher reflexivity, below. The analysis (Chapter Four) addressed the criteria of adequacy of data and adequacy of interpretation, by using illustrative excerpts to sustain a thickness of argument. In relation to the quality criteria for poststructuralist research (see section 3.5), the analysis also addressed authenticity by elaborating participants' subject positions and attendant power relations. Through its genealogy (Chapter Two) and analysis this research has indeed attempted to locate the discursive phenomenon of dual diagnosis historically, and to raise awareness of issues of power in dual diagnosis practice. Again, it is for the reader to assess its merits in these areas.

Regarding the criterion of transgressive validity (see section 3.5), this study's ambitions were modest, as noted above. However, I argue that this research has demonstrated a capacity to incite discourse in relation to dual diagnosis and dual diagnosis practice, and thus contribute to a critical social science, in several ways. First, the genealogy offered in this thesis has critiqued medical constructions of madness and addiction, and has argued that they may share a core discourse of moral failing. Moreover, contemporary constructions still seem unable to conceptualise addiction without reference to this moral discourse. This seems in keeping with poststructuralist studies by Hodges (2002), which posits that therapy is less a psychological interaction than a moral one that gains its power from "relocating persons within a therapeutic moral order" (p. 476), and Guilfoyle (2002), which locates therapy as a social institution that promotes specific culturally sanctioned modes of subjectivity (Avdi & Georgaca, 2007).

Further, through the focus on language afforded by its poststructuralist perspective, this research has proposed that dual diagnosis is a problematic discursive phenomenon, which may account for the current confusion and disquiet that characterises the literature in this area. Finally, I argue, the three circulating discursive regimes and five subject positions identified in the analysis are of interest from a transgressive perspective. The former provided the frames of intelligibility for participants' accounts, and illustrated the diverse and contradictory expert knowledges they resourced in their talk about this practice. They may therefore provide a critical resource for dual diagnosis practitioners, to raise awareness of these expert knowledges and their attendant power games, which they may encounter in their own work. In rendering participants' talk contradictory, they also illustrate the apparent paucity of dual diagnosis discourses and the need for new ones in the field.

The subject positions, too, may incite discourse; not least because of the problematic power effects that they engendered or perpetuated. Therefore they are

argued to illustrate the dangers of practitioners uncritically resourcing expert knowledges, and so being unthinkingly talked by the language they use in their work with dual diagnosis clients, in turn instigating problematic practitioner-client relations. Moreover, the finding that the ostensibly resistant Advocate subject position seemed to perpetuate dominating power relationships it intended to contest is of particular interest from a transgressive perspective. It is argued to demonstrate the unintended consequences that may accompany attempts at destigmatisation in practice. It may therefore exemplify Foucault's (1991a) maxim that "everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to a hyper- and pessimistic activism." (p. 343). This research similarly demonstrates that practitioners need to bring an activism in the form of reflexivity to their work, to try to avoid perpetuating iniquitous power relations in their practice with dual diagnosis clients.

5.4.4 Revisiting researcher reflexivity.

Following on from the consideration of researcher reflexivity (see section 3.4), I will now comment on reflexivity in the context of data collection, the analytic process and the overall research. As noted above, within poststructuralist research it is acknowledged that the researcher will influence every aspect of the research process, and that bias is unavoidable (Harper, 2003; Finlay & Gough, 2003). This is a consequence of the researcher's own technologies of the self, which are inevitably at play throughout the research process. His or her attention will inevitably be drawn towards some phenomena, to the exclusion of others. FDA additionally acknowledges the interpretive nature of knowledge, and the mutual construction of interviews (Randol, 2014; Willig, 2013). This lends greater importance to researcher reflexivity, which may offer a critique of the expert knowledges and frames of intelligibility that

influence the interpretations of the data. While bias is inevitable, then, one should attempt to make it as explicit as possible, thereby trying to counteract it.

Furthermore, as counselling psychology moves toward an increasingly relational world view that emphasises co-createdness in the therapeutic encounter and brings its postmodern assumptions to the fore, it increasingly promotes critical reflection as a tool in training and practice, and a required professional competency (Milton, Craven & Coye, 2010; Rizq, 2010). This increasing interest in personal and professional reflexivity is echoed in counselling and psychotherapy more generally (Kuchuck, 2014). Yet I acknowledge here, again, that reflexivity is itself a discourse from a Foucauldian perspective, so its prioritisation may enact unintended power effects. Indeed, its codification as a professional competency may lead to reflexivity becoming a normative and regulatory practice. Therefore it is not regarded as an end point in itself, but rather a means to develop professional practice. I again consider reflexivity here within Gemignani's (2017) critical constructionist paradigm, which is suited to this research's epistemological stance (see section 3.4).

I approached this study as a doctoral-level student, with the agenda of doing doctoral-level research. As discussed above (section 3.4), I was also motivated by my experiences of working in a statutory drug service, where I observed the dominating and excluding power relations to which dual diagnosis clients were subject. This engendered a sense of injustice, which led me to approach this study with an activist-researcher agenda. It led me to become subject to discourses of injustice and iniquity in relation to dual diagnosis practice, unthinkingly. Thus the technologies of the self through which I constituted myself as a researcher may initially have led me to conceptualise dual diagnosis practice in simplistic binaries of right and wrong.

I approached my first interviews with this agenda. I joined in participants' accounts when they conformed to it, and perhaps influenced these participants to adopt particular subject positions. As I began to analyse these interviews and

interrogate the power-laden discourses and subject positions therein, I realised that I seemed endorse particular subjectivities without understanding I was doing so. Moreover, I recognised that through my experiences in the drug service I had become subject to recovery discourses and had mobilised an Advocate subject position that had informed my activist-researcher stance. I had therefore perpetuated the power relations I had intended to undertake this research to contest.

This was a troubling realisation. However, I began to become more suspect of my own expert knowledges, how I deployed them, and how they located me within particular power relations. This afforded a more agnostic and critical subjectivity in undertaking this research, which seemed to allow a more thoughtful response to participants' talk. It has also enhanced my own development as reflexive CoP, and has provided an object lesson in the Foucauldian viewpoint that we are all subject to discourse. My own journey in undertaking this research and developing a more reflexive stance toward practice, while attempting to be mindful of the power effects of such a stance, may thus demonstrate how a poststructuralist reflexivity can encourage practitioners to reposition themselves in relation to their knowledge, their selves and their clients, and see alternative possibilities that may afford a more meaningful practice (Loewenthal & Snell, 2003)

5.4.5 Suggestions for future research.

This research focused on practitioner-participants' accounts of working with dual diagnosis clients, and the discursive constructions and power-laden subject positions therein. Some suggestions for future research are noted here, in light of its findings.

As discussed, this research's relevance to counselling psychology was reduced by recruiting only two CoPs in its opportunity sample. Therefore, a similarly designed study using an exclusive CoP sample seems worthwhile. This would afford

an investigation of both the power games in CoPs' accounts of working with dual diagnosis clients, and the extent to which qualified CoPs are aware of the discursive power games in their talk, and whether they can mitigate these effects to produce a practice in keeping with counselling psychology's egalitarian ethos. Furthermore, this might offer some insight into how CoPs negotiate the multiple and contradictory expert knowledges that inform their practice, which Rizq (2006) has noted is a source of emotional strain to CoP trainees.

Another potential study, again using a similar design, might investigate dual diagnosis clients' accounts of clinical practice. This would be of interest in its own right, I argue, in affording insight into the discourses to which these clients are subject, and the discursive resources they draw upon in mobilising their subjectivities as clients within therapy sessions. This might illustrate how dual diagnosis clients may be "done" by language, in therapeutic practice. It may also effectively function as a critique, in testing the limits of—and perhaps providing alternatives to—the expert therapeutic knowledges that inform the accounts presented in this research.

As acknowledged above, FDA has been criticised for its potentially limited clinical relevance (Avdi & Georgaca, 2007). This research's use of interviews is also a possible limitation, in allowing researcher bias that may be excessive. Therefore, a FDA of therapy sessions with dual diagnosis clients might generate more naturalistic analyses of the discursive power games at play in working with this client group. Hodges' (2002) study of radio therapy sessions, which demonstrated the normative and power-laden transformations of callers' issues, provides an example of FDA's potential value in this regard.

5.5 Overall Conclusions

In this research, the radical approach to and reformulation of language that a poststructuralist FDA facilitates, has been applied to ten psychological practitioners'

therapeutic accounts of dual diagnosis practice. As a hermeneutic process, this research produced one possible reading of the data, and makes no claims to universality or generalisability of its findings. Its contribution and value rests on the critical perspective that it offers on dual diagnosis practice, which invites practitioners to become aware of the power-laden truth claims in their talk and the subject positions that they may unknowingly be located within. Most notably, it is argued to demonstrate the importance of practitioners' awareness of being talked by the language they use, which may perpetuate problematic practitioner-client relations. It additionally argues that this critical perspective may facilitate reflexivity in practice with dual diagnosis clients, and perhaps with clients more generally. In so doing, it is argued to demonstrate the capacity of Foucauldian-informed research to shed light on problematic areas of practice in novel and unexpected ways.

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Appendix A

The research for this project was submitted for ethics consideration under the reference PSYC 16/ 207 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 23.03.16.

Appendix B

University of Roehampton London

CENTRE FOR RESEARCH IN SOCIAL AND PSYCHOLOGICAL TRANSFORMATION (CREST)
DEPARTMENT OF PSYCHOLOGY

DATA STORAGE AND PROTECTION PROCEDURES

SOURCES

These procedures are informed by, and consistent with, the following sources:

- Roehampton *University Data Protection Policy*, University of Roehampton, May 2010 (revised).
- *Ethical Guidelines for Researching Counselling and Psychotherapy*, British Association of Counselling and Psychotherapy, 2004.
- *Encrypting Confidential Data using Windows XP*, Counselling and Psychotherapy Research Guidelines, Counselling Unit, University of Strathclyde (available via Google Group).
- *Ethical Principles for Conducting Research with Human Participants*, British Psychological Society (accessed Sept. 2008).
- Personal communications with Ralph Weedon, Data Protection Officer, University of Strathclyde

RESPONSIBILITIES

- The Chief Investigator has overall responsibility to ensure that the appropriate data storage and protection guidelines are followed.

NON-ANONYMISED/PERSONAL DATA

- Non-anonymised (or 'personal') data refers to any form of documentation or media – electronic or otherwise – in which an individual is identifiable. This includes, but is not limited to:
    - signed consent forms
    - client identity forms (including DOB, GP details, gender etc)
    - video recordings

  Note: even if no name or other obvious data is involved that would identify an individual, data such as date of birth, student matriculation number, national insurance number can be 'triangulated', perhaps with other data a third party has acquired, in such as way as to effectively identify someone. Anything that can be used in this way is therefore to be considered personal data.
- Collection of non-anonymised data will be kept to a minimum, and will only be obtained where it is ethically necessary (as in the case of signed consent forms), or where it clearly adds to the scientific value of a project (for instance, the video recording of counselling sessions).
- Non-anonymised data will be kept for ten years.

- All non-anonymised data will be clearly labelled with a date at which it should be destroyed.
- Non-anonymised data will be destroyed in a way which ensures that the data cannot be recovered in any way.
- Non-anonymised data will be kept physically and/or electronically separate from related anonymised data so that links can not be made between the two sets of data.
- Non-electronic personal data, such as tape recordings and signed consent forms, should be kept in a locked and secure location at all times, and, wherever possible, at the University of Roehampton.
- Electronic personal data will be encrypted and should always be kept on a password protected storage device: wherever possible a PC or network drive located at the University of Roehampton.
- Personal data should not be kept on – or transferred to – laptops, USB sticks, CDs or other mobile/portable devices unless absolutely necessary. As soon as such data is transferred to a secure University location, it must be removed from the portable device such that it cannot be recovered in any way.
- *Should it be necessary to transfer personal data from person to person, this should be done in a secure manner (i.e., by hand or by recorded delivery), always separate from any anonymised data. Any posted materials should be marked 'private and confidential' and sent recorded delivery.*
- For the duration of a study, non-anonymised data may, if absolutely necessary, be stored (in the manner identified above) by investigators other than the Chief Investigator (for instance, where a student is analysing video tapes of counselling sessions). However, on completion of the write-up of the research, all non-anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

ANONYMISED DATA

- Anonymised data refers to any form of documentation or media – electronic or otherwise – in which an individual is in no way identifiable. This includes, but is not limited to:
    - SPSS spreadsheets in which identifying characteristics (such as age) are not recorded
    - completed questionnaires: qualitative or quantitative
- Anonymised data may be kept for an unlimited period, and may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).
- Non-electronic anonymised data will be kept in a locked and secure location at all times, ideally at the University of Roehampton.
- Electronic anonymised data may be stored electronically. This should always be to the highest possible standard of confidentiality: for instance, storage in an encrypted folder. It may also be kept on a password protected storage device, ideally at the University of Roehampton and, wherever possible, will be encrypted. Transfer and storage on portable/mobile devices (such as USB pens) should be kept to a minimum.

- Transfer of anonymised data should be conducted to the highest standards of confidentiality, always separate from any non-anonymised data. Any posted materials should be marked 'private and confidential.' If anonymised data is transferred via email, it should be transferred by the receiver to an encrypted portion of a hard disk as soon as possible, and both sender and receiver should hard delete the email/attachments from their email server.
- For the duration of a study, anonymised data may be stored (in the manner identified above) by investigators other than the Chief Investigator. However, on completion of the write-up of the research, all anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

PARTIALLY ANONYMISED DATA (ALSO KNOWN AS PSEUDO-ANONYMISED DATA)

- This section refers to any form of documentation or media – electronic or otherwise – in which it is highly unlikely that research participants can be identified, but in which the possibility of triangulation exists. This may include, but is not limited to:
    - audio recordings

  Note, if such media includes clearly identifying content (for instance, an interviewee reveals their name or that of their husband on an audio recording), then it will be treated as non-anonymised data until those identifying characteristics are removed.
- Wherever possible, partially anonymised (and non-anonymised) data should be scrutinised and all identifying details should be deleted/erased (for instance, identifying features on transcripts, such as names of partners, should be deleted or blacked out).
- Where all identifying details of partially anonymised data have been deleted/erased, this data will be treated as anonymised data, and subjected to the same procedures as above.
- In instances where partially anonymised data can not be fully anonymised (for instance, audio recordings in which the participant may be identifiable from their voice), this data will be kept for ten years, and will be stored according to the protocols for non-anonymised data.
- Within this ten year period, partially anonymised data may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).

THE EIGHT GENERAL PRINCIPLES OF THE DATA PROTECTION ACT, 1998

- Personal data shall be processed fairly and lawfully (with specific requirements regarding sensitive personal data).
- Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
- Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
- Personal data shall be accurate and, where necessary, kept up to date.

- Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
- Personal data shall be processed in accordance with the rights of data subjects.
- Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against loss or destruction of, or damage to, personal data.
- Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Appendix C

PARTICIPANT CONSENT FORM

Title of Research Project: A Qualitative Investigation of Psychological Practitioners' Experiences of Working Therapeutically with Dual Diagnosis Clients.

Thank you for considering participation in this research. Please read carefully the information below, and do not hesitate to ask me if you have any further questions.

Brief Description of Research Project, and What Participation Involves:

This research aims to investigate how psychological practitioners understand and experience working therapeutically with dual diagnosis clients. It also also aims to examine how psychological practitioners conceptualise dual diagnosis.
This research hopes to recruit 10 participants. Participants will be qualified psychological practitioners with a minimum self-identified 6-month experience of working with dual diagnosis clients. Participants will be accredited by the BACP, UKCP, BABCP, BPC or BPS.

In this study, you will take part in a 60- to 90- minute interview with the researcher, which will be audio-recorded. Interviews will be conducted at your workplace or the University of Roehampton. There will be three main areas of exploration in this interview: your understanding or conceptualisation of dual diagnosis, your past experiences of working with dual diagnosis clients, and any thoughts you may have about working with client group in the future.

This project has been approved under the procedures of the University of Roehampton's Ethics Committee.

Confidentiality and Anonymity:

Your anonymity will be protected at all times. All data will be securely stored in encrypted and password-protected computer files and locked filing cabinets. No one outside of the research team will have access to your individual data. People within the research team will not be aware of any links between your identity and any collected data. Signed consent forms will be stored separately from all other data. Your identity is not traceable, and will be protected in the publication of any findings.

Confidentiality will be kept at all times unless there is a real concern about your safety or other's safety.

Right to Withdraw:

You may withdraw from participation from this study at any point during or after this interview, without giving a reason. However, if you choose to withdraw after submission of the first draft of a thesis based on these research findings, your data may still be used in collated form. In order to withdraw, please contact the researcher and provide the participant number on the Debrief Form.

Investigator Contact Details:

Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: treadwem@roehampton.ac.uk
Tel: 07796 957014

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details:

Dr. Janek Dubowski
Director of Postgraduate Provision
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London SW15 4JD
Email: j.dubowski@roehampton.ac.uk
Tel: 020 8392 3214

Head of Department Contact Details:

Dr. Diane Bray
Head of Department
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 020 8392 3627

Appendix D

Participant ID Number:

PARTICIPANT DEBRIEF

Title of Research Project: A Qualitative Investigation of Psychological Practitioners' Experiences of Working Therapeutically with Dual Diagnosis Clients.

Thank you very much for taking part in this study, we appreciate your valuable contribution.

This study aimed to examine how psychological practitioners experience working with dual diagnosis clients. It used interviews to collect appropriate data, to allow the researcher to materialise the research objectives.

- I agree that this interview has been conducted professionally and ethically.
- A copy of the transcription will be sent to me within a month after the interview.
- My anonymity is ensured in this project and in all future publications that may derive from this thesis.

Participant:…… Researcher: ……....

Signature:……. Signature: …….

Date:…….. Date: ……....

Researcher Contact Details:

Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: treadwem@roehampton.ac.uk
Tel: 07796 957014

If the interview caused any emotional distress or discomfort please speak to your clinical supervisor. Alternatively, if you would like to access an independent source of support you may find it useful to contact your GP or approach any of the following professional bodies:

BPS	UKCP	BACP
www.bps.org.uk	www.ukcp.org.uk	www.bacp.co.uk
Tel: 0116 254 9568	Tel: **020 7014 9955**	**Tel:** 01455 883300
Email: enquiries@bps.org.uk	Email: info@ukcp.org.uk	Email: bacp@bacp.co.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details:

Dr. Janek Dubowski
Director of Postgraduate Provision
Department of Psychology
University of Roehampton
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Tel: 020 8392 3214

Head of Department Contact Details:

Dr. Diane Bray
Head of Department
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Appendix E

Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: treadwem@roehampton.ac.uk

To whom it may concern,

I am a counselling psychologist in training on the Counselling Psychology Doctoral programme at the University of Roehampton. I am researching psychological practitioners' experiences of working with dual diagnosis clients. This study has been approved under the procedures of the University of Roehampton's Ethics Committee.

I am looking to recruit ten qualified psychological practitioners who have a minimum of 6 months' experience with this client group, to participate in my research. I would like to interview these practitioners for 60 to 90 minutes about their experience of working therapeutically with dual diagnosis clients. Interviewees should be accredited by the BACP, UKCP, BABCP, BPC or BPS.

If you are willing to advertise this research in your organisation, please use the leaflet attached to post on any noticeboards or give it out in team meetings. If you know of any counselling psychologists or psychotherapeutic practitioners who may be willing to take part in this research, please contact me or the Director of Studies at the address below. And if you have any further questions please do not hesitate to contact me or the Director of Studies.

I believe that the proposed study will meaningfully contribute to the research base on dual diagnosis. This may be beneficial for practitioners and the wider clinical field in which they practice, and dual diagnosis clients themselves. I would be grateful if you would consider helping me recruit for this research.

Thank you in advance for your time and help.

Yours sincerely,

Matt Treadwell
Counselling Psychologist in training
treadwem@roehampton.ac.uk

Contact Details:

Researcher:
Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD

Director of Studies:
Dr Janek Dubowski
Director of Postgraduate Provision
Department of Psychology
University of Roehampton
Whitelands College
London SW15 4JD
Email: j.dubowski@roehampton.ac.uk
Tel: 020 8392 3214

Appendix F

University of Roehampton London

Are you a psychological practitioner currently working with Dual Diagnosis clients?

I am conducting a study on practitioners' experiences of working therapeutically with dual diagnosis clients.

I am a counselling psychologist in training on the Counselling Psychology Doctoral programme at the University of Roehampton. I would like to interview qualified psychological practitioners who currently work with dual diagnosis clients, and have at least 6 months' experience with this client group. Interviewees should be accredited by the BACP, UKCP, BABCP, BPC or BPS. Interviews would last no longer than 90 minutes.

While there is increasing research in the dual diagnosis field, practioners' experience of working with dual diagnosis clients remains an under-researched area. I believe that a greater understanding of practitioners' experiences of working therapeutically with dual diagnosis clients is valuable and could contribute significantly to dual diagnosis research. Developing an understanding of practitioners' experiences of working with dual diagnosis clients may benefit not only clinicians and the services in which they practice, but also dual diagnosis clients themselves.

If you think you or anyone you know might be interested in participating in this research or if you would like more information, please contact me in confidence at:

Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD Email: treadwem@roehampton.ac.uk

Appendix G

Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: treadwem@roehampton.ac.uk

Dear Sir or Madam

I am a counselling psychologist in training on the Counselling Psychology Doctoral programme at Roehampton University. I am researching counselling psychologists' or psychotherapeutic practitioners' experiences of working with dual diagnosis clients. This study has been approved under the procedures of the University of Roehampton's Ethics Committee.

I am looking to recruit ten qualified psychological practitioners who have a minimum of 6 months' experience of working therapeutically with dual diagnosis clients, to participate in my research. I would like to interview these practitioners for 60 to 90 minutes about their experience of working therapeutically with dual diagnosis clients. Interviewees should be accredited by the BACP, UKCP, BABCP, BPC or BPS.

I understand that you may currently work with dual diagnosis clients in your practice. So I am writing to see if you would be interested in participating in this research. If so, please contact me or the Director of Studies at the address below. If you know of any other counselling psychologists or psychotherapeutic practitioners who may be willing to take part in this research, I would be grateful if you would contact me as well. And if you have any further questions please do not hesitate to contact me or the Director of Studies.

I believe that the proposed study will meaningfully contribute to the research base on dual diagnosis. This may be beneficial for practitioners and the wider clinical field in which they practice, and dual diagnosis clients themselves. I would be grateful if you would consider helping me recruit for this research.

Thank you in advance for your time and help.

Yours sincerely,

Matt Treadwell
Counselling Psychologist in training
treadwem@roehampton.ac.uk

Contact Details:

Researcher:
Matt Treadwell
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London, SW15 4JD

Director of Studies:
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